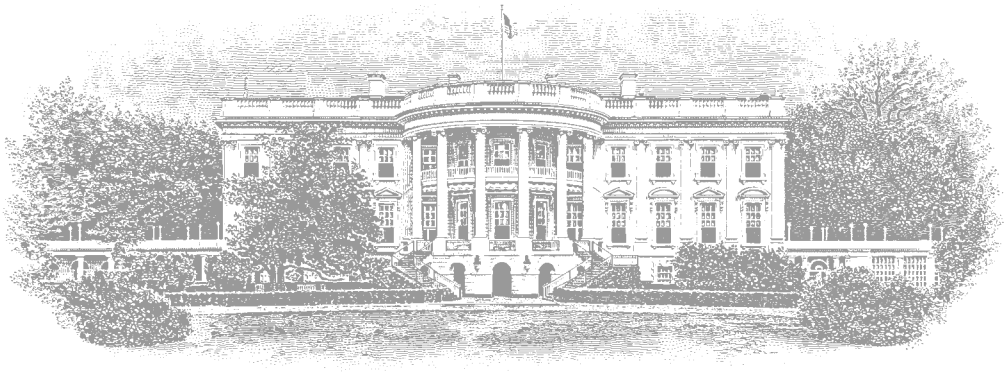
The National
Methamphetamine Drug Conference

CONFERENCE PROCEEDINGS



May 28-30, 1997
Omaha, Nebraska

Sponsored By:
The Office of National Drug Control Policy

In Collaboration With:
The Office of U.S. Senator Robert Kerrey
The University of Nebraska Medical Center

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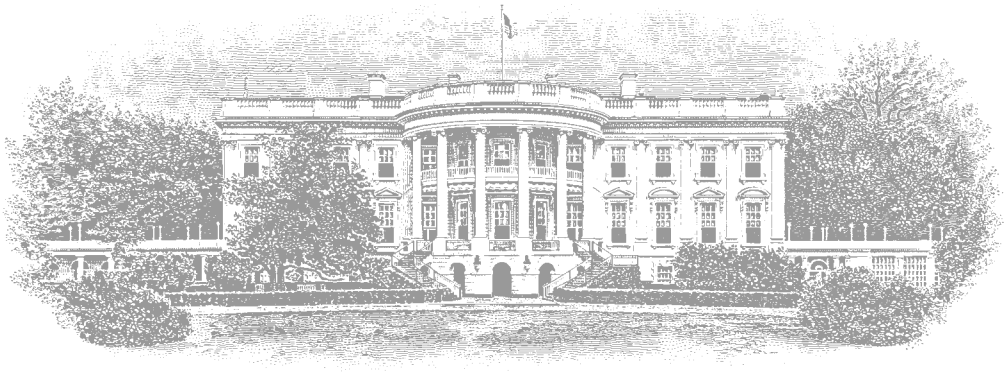

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Sponsored By:
The Office of National Drug Control Policy
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Acknowledgments

This report is based upon presentations and discussions at the National Methamphetamine Drug Conference held at the Red Lion Hotel, May 28-30, 1997, in Omaha, Nebraska. All remarks were edited for clarity. It is our hope that we accurately captured each speaker's intent. Any errors or omissions in content are entirely the fault of the editorial staff.

The remarks attributed to speakers do not necessarily reflect the opinions or official policy of the agencies they represent.

In this report, the term "meth" is used interchangeably with methamphetamine.

The Office of National Drug Control Policy acknowledges the generous funding given by the University of Nebraska Medical Center (UNMC). The mission of the Medical Center is to improve health in Nebraska through premier educational programs, innovative research, quality patient care, and outreach to underserved populations. Additionally, ONDCP extends its appreciation to UNMC for providing workgroup facilitators, recorders, and administrative staff.

This publication is also available on the White House Office of National Drug Control Policy World Wide Web site at:

www.whitehousedrugpolicy.gov

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National Conference Summary

Methamphetamine is a synthetic stimulant that can produce extreme aggressiveness and violence. Historically, concentrated abuse of this drug was in the West and Southwest but is now reported to be spreading to the Midwest and the eastern portion of the United States. Methamphetamine production entails extreme environmental risks. Clandestine laboratories produce large amounts of toxic waste, much of which is dumped into the ground or in waterways. The cost to clean up these chemical toxins can easily run into thousands of dollars per site.

Given the resurgence of methamphetamine abuse, the White House Office of National Drug Control Policy (ONDCP) convened the National Methamphetamine Drug Conference, May 28-30, 1997, in Omaha, Nebraska. The purpose of the conference was to gather information for refining the national methamphetamine strategy by assessing current trends and soliciting recommendations from experts on methods to reduce the methamphetamine threat.

The structure of the conference was key to its effectiveness. A national perspective on this problem required the collective effort of public and private-sector agencies and organizations. Experts from the fields of law enforcement, prevention, and treatment at federal, state and local levels were invited, as were business and public interest groups from across the country. More than 375 attendees from thirty-five states and territories as far away as Guam participated. Fifteen informative exhibits helped illustrate the problem and demonstrate initiatives against methamphetamine abuse.

The conference provided a fitting agenda for this broadly representative group. At the morning session, plenary presentations summarized the methamphetamine problem, including an historical overview of stimulant abuse in the United States, a treatment segment on the physiological effects of methamphetamine abuse, a research presentation with current usage data taken from drug arrestees, and an intelligence briefing about methamphetamine trafficking patterns and production methods. A question and answer period followed each presentation.

During the afternoon session, conference participants gathered in six working groups to discuss key areas and develop recommendations for future efforts. The working groups reviewed prevention, education, treatment, clandestine labs, drug courts, and precursor chemical control. The following morning each working group presented a summary of its discussions and specific recommendations for the strategy.

The second day included a panel discussion among medical experts ranging from academic researchers to hospital physicians. A National Drug Control Strategy presentation demonstrated the importance of the conference to the national plan. In support of the conference, keynote addresses by Attorney General Janet Reno, Senator Bob Kerrey, Governor Ben Nelson, and DEA Administrator Thomas Constantine highlighted efforts underway.

The following document chronicles the conference proceedings. Appendices include the conference agenda and an overview of working-group briefings and discussions. ONDCP encourages readers to share this report widely.

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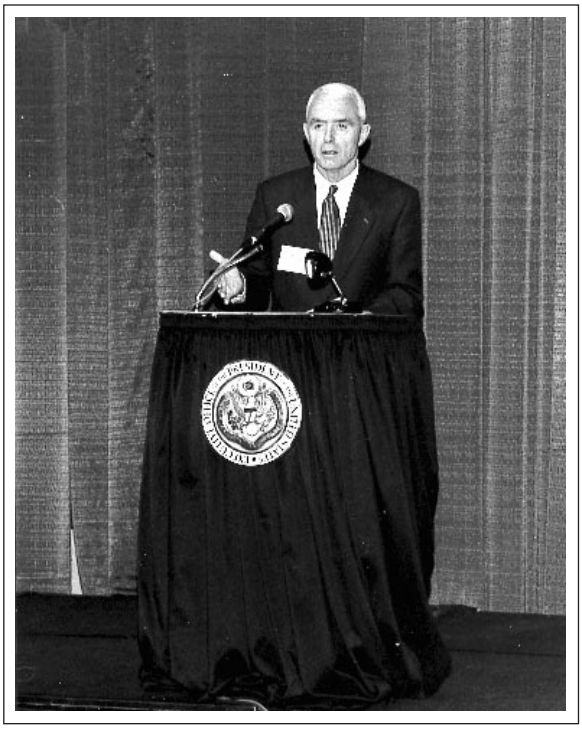
Opening Remarks

BARRY R. McCAFFREY, DIRECTOR
OFFICE OF NATIONAL DRUG CONTROL POLICY

We welcome you to an important interactive conference; the most significant contribution you can make to these two days is your time and expertise. Senator Kerrey, thank you for your support of the Office of National Drug Control Policy and for your leadership in the fight against drug abuse. Governor Ben Nelson, thank you for hosting this conference. Luceille Fleming, president of the National Association of State Alcohol and Drug Abuse Directors, thank you for your support and leadership within the treatment community. We also thank Chancellor William Berndt, a noted pharmacologist and head of the University of Nebraska Medical Center. His institution was fundamental in bringing you here and putting together this meeting. Chancellor Berndt supported our efforts with a $10,000 grant and more than forty staff. We are enormously grateful for his sponsorship.

We entered the 1980s and were inundated by cocaine and its derivative, crack; we overlooked what happened with cocaine decades earlier. There is no reason to accept this outcome with the methamphetamine threat.

Many of us understand law enforcement, treatment or prevention, but we have not grasped the nature of methamphetamine abuse in a collective fashion. I asked the President for authority to bring together a national group of experts to refine our strategy on methamphetamine abuse in America. I commend you to read the President's letter that expresses the conference purpose: to define and understand all aspects of the methamphetamine problem. This conference gives us the opportunity to exchange information about the methamphetamine threat. We intend to record the dialogue, reproduce it, and send copies to educators, law enforcement officials, and medical practitioners around the country.



Barry R. McCaffrey, Director, ONDCP, provides opening remarks at the National Methamphetamine Conference, May 28-30, 1997.

Professor David Musto from Yale University will give our first presentation on the history

of stimulant use. With his background in medicine, psychiatry, and history, Dr. Musto's contribution is critical. As Americans, we are extremely poor at finding the historical starting point when we analyze problems. With cocaine, in particular, it is astonishing that we overlooked the impact this drug had on our nation's history. We forgot the lessons learned in the past. We entered the 1980s and were inundated by cocaine and its derivative, crack; we overlooked what happened with cocaine decades earlier. There is no reason to accept this outcome with the methamphetamine threat. Professor Musto's work represents the hope that, if we use history effectively, we can improve our situation.

Dr. Alan Leshner, director of the National Institute on Drug Abuse (NIDA), will speak. The National Institutes of Health (NIH) are an American treasure. Dr. Harold Varmus and other very special people affiliated with that institution are a reservoir of knowledge and provide a frontal assault on drug abuse. I borrow Dr. Leshner's charge and take it as my own: Let us replace ideology with science in the discussion of the drug issue so we can better understand what we say. When we deal seriously with policy issues, we go to the researchers and doctors for the scientific basis of a problem. Dr. Leshner is one of the nation's preeminent drug experts; we look forward to hearing his remarks.

Jeremy Travis, director of the National Institute of Justice (NIJ), is also here. He is one of the great people in our government. Janet Reno, who was heavily involved with this issue as a young prosecutor in Miami and who is an advocate for children, has promised creative research and activities from the Department of Justice. Jeremy Travis is her intellectual point man. We welcome his insight on the problem.

Randy Weaver from the National Drug Intelligence Center (NDIC) will address us and give us a picture of the national context in which we operate. The director of NDIC, Dick Cañas, is also here, and we look forward to hearing his remarks.

Tom Constantine will speak at lunch. He leads seven thousand DEA officers and professionals stationed worldwide and has been in law enforcement for thirty-four years. This man knows what he is talking about; he is a no-nonsense fellow. The law-enforcement aspect of drug abuse must be the fundamental base for prevention and treatment programs. No one knows more about the drug issue than Tom Constantine.

Attorney General Janet Reno will speak tonight. She is the author of the *National Methamphetamine Strategy* and will continue to be the quarterback for us. She will also help implement the National Methamphetamine Control Act, which proscribes certain illegal manufacturing and use of precursor chemicals. The Act gives law-enforcement officers another tool to limit illegal production of methamphetamine. We look forward, as always, to hearing her views.

Our work groups this afternoon will be infused with expert coverage of six key topics. In prevention, we have Martha Gagne, director of the American Council for Drug Education, and Leslie Bloom of the Partnership for a Drug-Free America, who will talk about public information initiatives at home and at work. If we have one fundamental goal to achieve, it is prevention. If we explain to the American people what methamphetamine is and how it affects human life, citizens will organize and make positive change.

It is not business-as-usual when we deal with methamphetamine labs. We face the potential for mass casualties as well as chemical processes gone wrong.

The next topic we will address includes education, school, and community partnerships. This workgroup will be chaired by Ken Bird, superintendent of Westside Community Schools in Omaha. With partnership and coalition building, our efforts to reduce methamphetamine abuse will be more effective.

Dr. Everett Ellinwood, professor of psychiatry and pharmacology at Duke University, will chair the workgroup devoted to treatment, which may be one of the great gaps we need

to fill. We must give our medical community, sociologists, and law-enforcement personnel a better grasp of treatment protocols and pharmacological prevention tools to address this problem.

Luke Galant, program manager of the Law Enforcement Branch of the Bureau of Justice Assistance, will serve as our chair on clandestine labs. Hydriodic acid, red phosphorous, and phosphine gases used in these labs are lethal to waterways and reservoirs as well as to people in hotels where temporary labs are set up. Law-enforcement officers tell us local political leadership is concerned that police not alarm the populace by wearing chemical protective clothing, kevlar helmets, and other gear during lab takedowns; this leadership wants law enforcement to adopt a more benign police presence. The time has come to wake up. It is not business-as-usual when we deal with methamphetamine labs. We face the potential for mass casualties as well as chemical processes gone wrong. We as a nation spend millions to learn which chemicals were released in the Gulf War; in the same manner, we must attend to hundreds of methamphetamine labs that are cooking off, burning down, or exploding in America.

If we can save a third of the Americans involved in drug abuse through drug court treatment programs, we will make progress. Drug courts are better than the revolving-door alternative.

The next topic this conference will examine is drug courts. We have Judge Richard Shull, of Wichita, Kansas, to help us. Janet Reno and others in southern Florida originated the drug court innovation. Three years ago, we had a dozen drug courts in this county. Today, there are 200, and another 150 are in various stages of development. Drug courts are not a magic bullet and will not eradicate the drug problem or achieve a comprehensive cure. However, law enforcement personnel assure us that drug courts are extremely useful. If we can save a third of the Americans involved in drug abuse through drug court treatment programs, we will make progress. Drug courts are better than the revolving-door alternative. We need programs with strong judicial oversight, options for incarceration, and more monitoring. We look forward to hearing Judge Shull's ideas.

The final workgroup area is precursor chemicals. Laura Birkmeyer, assistant U.S. attorney in San Diego, will serve as chair. Handling the chemical problem is difficult. As soon as we find one solution, such as when we outlawed chemicals like P2P in the methamphetamine production process, the illegal manufacturers find other methods for ephedrine production. We must control precursors; we cannot allow small stores and pharmacies that know full well what they are doing to sell thousands of dollars worth of a product per day. These chemicals will then be used to devastate the environment and our families.

On Friday, we add a clinical panel to the conference agenda. Dr. Richard Rawson of the Matrix Institute, Dr. Everett Ellinwood from Duke University Medical Center, Dr. Tom Leland of the Community Health Center in Hawaii, Dr. Scott Lukas from Harvard and Dr. Michael Sise of Mercy Hospital in San Diego will speak. We shall discuss the drug challenge facing our physicians, peace officers, and our entire society.

The material we assembled for you today is most important, starting with the *1997 National Drug Control Strategy*, which we write to coordinate national drug control policy as required by law. On pages 30 and 31, this document summarizes our strategy in five goals and 32 objectives. The President published this document in April. We hope to gain support among our Congressional oversight authorities to retain the *National Drug Strategy* as a conceptional structure for the next decade to organize our thinking, to organize our budgets, and to organize our approaches to this problem. We are writing performance measures to gauge the effectiveness of the strategy. We will go to Congress this year with the thirty-two objectives and the next generation of a five-year budget. We will reveal the

targets we can achieve and the outcomes we seek.

I do not think this task will be easy. Within three to four years, we must operate the *National Drug Control Strategy* with the same degree of seriousness and purpose with which IBM or the national security process operates. I urge you to learn more about the *National Drug Control Strategy*. It entails a dynamic process to meet a dynamic threat. The approach must be comprehensive and sustained, lasting for at least ten years. James McDonough, our senior strategist, will talk more about the Strategy tomorrow.

The next document is the *1996 National Methamphetamine Strategy*. Attorney General Janet Reno and many people in the Department of Justice, along with the assistance of ONDCP, produced this strategy. We will eventually update this document, but it already provides very good guidance. We have the bipartisan support of Congress, and many committed people are involved, including Senator Bob Kerrey.

A must-read publication from the Substance Abuse and Mental Health Services Administration (SAMHSA) is the *Proceedings of the National Consensus Meeting on Methamphetamine*. This document has implications for prevention, treatment and research. When we talk to the public, we constantly warn about the effects of drugs on the brain. Studying the impact of drugs on human behavior helps us understand what methamphetamine does, in particular, to young people. Medical information is also useful when discussing methamphetamine with the news media. This publication provides another baseline data point and deserves your attention today.

The final document is the *1997 Methamphetamine Strategy Update* for the President. This was an internal document, but we published it to offer an overview of current events in the field. With the results of this meeting, we expect to publish another white paper that will complete our understanding of our posture against this drug threat.

Methamphetamine is a dangerously subtle drug. It may be used as a tool for weight loss.

More than 375 atendees from across the nation attended the conference.

Athletes use methamphetamine to give a burst of energy to their athletic capabilities while long-distance truckers use it to stay awake longer. In years past, offshoots of the amphetamine family were used by combat pilots and ground units on long patrols. For the weak, this drug conveys an illusion of empowerment: a 120-pound boy may feel like a giant killer after taking this drug. It produces an extended high for those seeking pleasure. Nevertheless, the drug's impact on bodily functions, mental acuity, social sense of responsibility, and psychological stability is deleterious.

We must get the word out. We must reveal the entire story about methamphetamine.

We must get the word out. We must reveal the entire story about methamphetamine. Violent, irrational behavior will become increasingly common in our society if we cannot prevent methamphetamine abuse. Such abuse may become a nightmare that causes long-term damage to children. This threat to American kids, who are also exposed to byproduct vapors during the drug's production, involves a dangerous chemical hazard. We must start working now.

When I shouldered this responsibility a year or so ago, I found many people on the Hill, in

both parties and both Houses who are knowledgeable about drug abuse in America. Among the people who have devoted their entire lives to fighting drug abuse are Orrin Hatch, Joe Biden, Denny Hastert, Rob Portman, Steny Hoyer, and Charlie Rangel. Many reasonable men and women want to make a contribution in this area and will support common-sense thinking when it is presented to them.

Senator Bob Kerrey has been a leader in the field. His background as a pharmacist gives him special insight into the problem while his years of public service help him understand policy implications. He is also a successful businessman who knows how to make change happen. He has been reticent to take credit for his efforts on the Hill, but I frequently benefit from his counsel and support. Please join me in welcoming our co-host, Senator Bob Kerrey.

Opening Remarks

J. ROBERT KERREY
UNITED STATES SENATOR FROM NEBRASKA

As General McCaffrey mentioned, it is sometimes astonishing how little we know about this methamphetamine problem. We tend to hold onto an old idea and are unprepared to deal with new, emerging drug threats. When I say we, I mean all of us. We, politicians included, sometimes get attached to an old solution. We think that solution will work in the future because it worked for us twenty or thirty years ago. Consequently, we become unwilling or reluctant to change; we do not see an alternative way. Yet, we have a chance today to change this behavior. We can and will make a difference against this dangerous methamphetamine threat.

As I reflect upon this problem, it seems to me we did not recognize this methamphetamine threat six or seven years ago. We need to think ahead. I believe we need a significant sense of urgency to solve this problem by reflecting on the past, present and future. We convened this conference so you can tell people like me what must be accomplished to improve our response to this dangerous drug problem. Do not worry about hurting my feelings or those of Barry McCaffrey or Tom Constantine, either – we want to know what must be done.

Tell us what must be done in the area of law enforcement, in the area of education, in the area of prevention, and in the area of treatment.

Senator Kerrey makes remarks about the need for new ideas to confront the drug challenge.

You are here because of your great intellect and talent and your great skill and experience. During the workgroups, I challenge you to listen to one another and to reach constructive conclusions that will help those like me, who have the responsibility for writing the laws of the land, and for those leaders like Governor Nelson, who have been advocating for resources and fighting the battle of drug abuse at the state level. You must help us to discover answers to this drug problem. We are making progress, but we cannot rest until we solve the problem entirely.

Tell us what must be done in the area of law enforcement, in the area of education, in the

area of prevention and in the area of treatment. We cannot be shy or reluctant to voice our ideas. Do parents need to spend more time with their children? Do we need to adjust our curriculum in the school? Must we change the structure of law enforcement? Do you have ideas about corporate America? We must demand that business leaders not pressure employees to produce more and more so that these workers turn to drugs to give themselves the power to do more and more.

I congratulate you for coming here. I appreciate your attendance and interest. Most of all, I applaud your past service in the cause of making this country a better place to live. With your help, we have confidence we will do even better. Thank you very much.

Opening Remarks

E. BENJAMIN NELSON
GOVERNOR OF NEBRASKA

Methamphetamine is a deadly threat in the great State of Nebraska. A year ago, a teenager in York, a community of about 8,000 people, collapsed and died at his high school prom from an overdose of methamphetamine. It shook the entire community, and it shook the State of Nebraska. Five years ago, the Nebraska State Patrol seized one-half of a pound of methamphetamine in the entire year, but through mid-May of this year, the State Patrol has already seized 70 pounds of methamphetamine. Our law enforcement officials tell us methamphetamine makes users more violent and is a cause for an increase in certain crimes.

Methamphetamine is a regional threat as well. The Drug Enforcement Administration seized 303 methamphetamine labs in the Midwest in the last year, compared to just 6 in 1992. The U.S. Attorney in Kansas City predicts the city's enforcement operations will seize up to 500 methamphetamine labs this year in Missouri alone. The number of methamphetamine users seeking treatment at publicly-funded treatment centers is up 300 percent in the last two years.

A year ago, a teenager in York, a community of about 8,000 people, collapsed and died at his high school prom from an overdose of methamphetamine.

Despite these facts, portions of our society refuse to acknowledge the serious nature of the problem and its dangerous impact on society. Let me give one example. Many of you are probably familiar with the popular ad campaign sponsored by the California Milk Board which encourages people to drink milk. The campaign slogan "Got milk?" is on t-shirts, billboards, magazines and television. Just a few days ago, a member of my staff saw a twisted version of this slogan on a t-shirt in the window of a record store. The slogan, instead of promoting the benefits of drinking milk, read "Got meth?"

Governor Nelson spoke about the growing methamphetamine threat in Nebraska and the Midwest.

I find nothing humorous about the comparison of the milk slogan to the methamphetamine slogan. In fact, the store selling the shirt is a block away from the main city library, and a block from the Lincoln Children's Museum and a movie theater. This shirt is on sale in our Capital city, a community where the police chief says methamphetamine has become the second most prevalent controlled substance of abuse. In response, we made a t-shirt that we think should be displayed in windows and

record stores across the state: "Meth stamped out." That is the message we need to get to our young people, and we enlisted the support of the Nebraska Broadcasters Association to work with us to educate our youth.

Last year, the Nebraska Broadcasters Association produced a series of public service announcements specifically aimed at methamphetamine. The idea for these PSAs grew from a regional methamphetamine conference Senator Kerrey and I hosted last August in Grand Island. At that conference, representatives from eight Midwestern states came together to share our experience, our successes, but also our frustration and growing concern about the methamphetamine threat.

We discovered state borders are boundaries with limited effect to stop illegal drug trafficking. Consequently, we developed a collective strategy to fight methamphetamine abuse. That strategy included efforts to bring more federal funding to the region, and Nebraska is now part of a five-state region designated as a High-Intensity Drug Trafficking Area (HIDTA). The $8 million in funds received in this region is enabling us to attack the problem in a coordinated way with joint investigations and prosecution and with the sharing of intelligence information among various law enforcement agencies.

The nature of the drug threat makes federal and state support even more crucial. Methamphetamine is hitting our rural areas and smaller communities hard. These areas are ill-equipped to deal with this drug threat; many have not had to deal with drug problems of any consequence before. These are places where people still feel comfortable leaving their homes unlocked and their keys in their cars, but this lifestyle is changing because, in large part, methamphetamine has entered the fabric of that life. We must do everything we can to give local officials the support and assistance they need to fight this battle.

We are working to stay ahead of the methamphetamine problem in Nebraska with several law enforcement task forces. Earlier this year, the Nebraska Crime Commission approved a grant for a special prosecutor in Western and Central Nebraska to help with the problem. In my Safe Streets Act of 1995, penalties increased for those convicted of methamphetamine offenses of 7 ounces or more. We know we need to do more, and we need your ideas to do better.

It is going to take everyone in this room and more to stop this killer. Government officials at every level must find the most cost-effective way to target our drug-fighting dollars for the best results. We need to enlist the support of the law-abiding rural couple to report suspicious activity at a nearby farmstead or that of the teenager who sets a good example by being drug free. We need this kind of commitment and support to be successful.

We are fighting for our children's lives, and we cannot afford to lose.

One life lost to methamphetamine is one too many: That of a 17-year-old high-school student who will never see another prom; the death of a neighbor whose car is stolen by a methamphetamine addict; that of a law enforcement officer whose life is on the line making a methamphetamine arrest or seizing a lab. The more we learn about our enemy, the more committed we must become to be the winners of this war. Your efforts at this conference are vitally important. We are fighting for our children's lives, and we cannot afford to lose. Thank you very much.

History: The American Experience With Stimulants

DAVID F. MUSTO, M.D., PROFESSOR OF HISTORY OF MEDICINE
YALE UNIVERSITY

For more than a century, Americans have praised stimulants, and alternately, Americans have condemned them as the most fearful of all dangerous drugs. Stimulants get their initial popularity because they offer a shortcut to goals admired as typically American: The ability to work without tiring, alertness to solve problems or cheerfulness regardless of the situation. Stay up later to follow the international markets. Drive farther without sleepiness. Faster, more and longer are promised by stimulants. Energy and efficiency are available simply by taking a substance, a substance that can be cheap as well as energizing.

Alexis de Tocqueville noted this American trait in the 1830s, decades before cocaine arrived as the first powerful stimulant. "It is odd to watch," he wrote, "with what feverish ardor the Americans pursue prosperity, and how they are ever tormented by the shadowy suspicion that they may not have chosen the shortest route to get it." For some Americans the "shortest route" has meant using stimulants, and this helps explain why. At the beginning of a stimulant epidemic, the drugs are favored by so many of those who are goal-oriented, trying to do their job better or working toward some achievement. When a new product promises to give them an edge, they are tempted to improve their chances with the help of chemical engineering.

The first widespread use of powerful stimulants began in the 1880s with the introduction of pure cocaine to the American market.

Dr. David Musto of Yale University describes the historical context of stimulant abuse in America.

With our immediate concern over methamphetamine and cocaine, we might think the current epidemic is America's first wave of stimulants. It is actually the second. During the first epidemic, cocaine was widely used – was legal at the beginning – and yet the epidemic did come to a close. Its closure was so complete, when Americans witnessed the rise of cocaine in the 1970s, they thought it was a new phenomenon, and, as it flourished, they despaired of it ever ending. What can we learn from that first epidemic?

The first widespread use of powerful stimulants began in the 1880s with the introduction of pure cocaine to the American market. Cocaine was not discovered in that decade. Its

isolation from coca leaves took place 20 years earlier, but it was in the 1880s when substantial production of cocaine got underway.

Preparing the way for pure cocaine was a variety of coca leaf extracts that contained varying amounts of cocaine and were taken by mouth. At the time, most were Vin Mariani, a combination of French red wine and coca leaf extract. Mariani's wine was popular as a tonic and stimulant in Europe and America. Angelo Mariani offered a discount to the clergy – Pope Leo XIII gave Mariani a gold medal – and he offered a further discount to orphanages. Famous people on both sides of the Atlantic allowed their names and faces to be used for Mariani's publicity, including Jules Verne, Charles Gounod, the sculptor of the Statue of Liberty, Frederic Bartholdi, cardinals, cabinet officers, explorers and even Thomas Edison. In one of Mariani's publicity books, even coca wine was touted as an antidote for melancholy and also as an invigorating stimulant for the healthy.

In what is now the *New England Journal of Medicine*, Dr. Archie Stockwell wrote in 1877 that:

> *Coca causes increased arterial action, stimulates the alimentary secretions and peristaltic action, diminishes weariness, strengthens the pulse, calms nervous excitement, retards waste, facilitates repair, alleviates spasms, and increases mental activity. In fact, it is an economizer of vital energy and an effective aid to nutrition. It invariably contributes to the mental cheerfulness and withal, not infrequently, causes unequivocal aphrodisia.*

And, after all, unequivocal aphrodisia is what people are looking for.

An American competitor to Vin Mariani, Metcalf's Coca Wine, advertised in the 1880s that it was a valuable tonic for "public speakers, singers and actors." Furthermore, "Athletes...and baseball players have found by practical experience that a steady course of coca taken both before and after any trial of strength or endurance will impart energy to every movement." This use of coca as a tonic was so popular that J.S. Pemberton of Atlanta, Georgia, concocted what he called a French Wine Coca in 1885; then, in 1886, he brought forth another coca drink but took out the controversial drug, alcohol, and called his creation "Coca-Cola." In its early years before the cocaine was eliminated, Coca-Cola was described as the "ideal brain tonic"(1893), and there was an ad for that. Thus "the pause that refreshes"(1929) has an interesting ancestry that testifies to the high regard in which coca drinks were held by the public.

If Coca-Cola and Vin Mariani had been the full extent of the public's exposure to coca, we might never have had the intense furor over cocaine that erupted in the decades after 1890 or that recurred during our present drug epidemic. Credit must be given to the advances of organic chemistry that first produced cocaine and also to the pharmaceutical industry that was able to manufacture and distribute cocaine in large amounts. As in the 1970s, cocaine a century earlier was at first expensive and restricted to those who could afford it, later becoming much cheaper and widely used.

Also paralleling our current wave of cocaine use was the initial description of cocaine as harmless and nonaddicting. You will recall the enthusiasm with which Sigmund Freud first wrote about and promoted cocaine. Even wise man Sherlock Holmes used cocaine in the first years after its introduction, although later he would abandon the practice. Within a year of its American introduction, Parke, Davis & Company had cocaine available for the public in 15 different forms. If one had regular crystal cocaine and it was not working, one had a very fine powder cocaine that cost a little bit more. There were also cocaine salve, cocaine cordial, coca wine, coca cigarettes and cocaine for inhaling.

> *A drug which, through its stimulant properties, could take the place of food, make the coward brave, the silent eloquent, free the victims of alcohol and opium habits from their bondage, and, as an anesthetic, render the sufferer insensitive to pain....*

Describing its remarkable new technology in 1885, the firm claimed cocaine to be:

> *A drug which, through its stimulant properties, could take the place of food, make the coward brave, the silent eloquent, free the victims of alcohol and opium habits from their bondage, and, as an anesthetic, render the sufferer insensitive to pain....*

A couple of years later, the United States Hay Fever Association announced it had chosen cocaine to be its official remedy. Although some physicians had issued serious warnings about cocaine's dangers, the power of its attraction submerged criticism as its use spread to everything from soda pop to headache remedies. After all, how bad can something be that makes you feel good?

...another parallel with our current cocaine problem that can be seen if you compare cocaine's portrayal in the 1970s as a safe, benign stimulant with its aura of extreme danger in the mid-80s.

In the early stages of a stimulant epidemic, even experts can be misled. Dr. William A. Hammond of New York and Washington, was one of the nation's leading neurologists, a novelist and a playwright. Dr. Hammond wrote extensively about the brain, was a professor at medical schools and would be someone you might well consult if you wanted an expert opinion on cocaine: He liked it, he recommended it and he took it. He even made his own wine/cocaine mixture that he boasted was stronger and more reliable than Vin Mariani. He rejected fearful stories about cocaine. Dr. Hammond "did not believe there was a single instance of a well-pronounced cocaine habit, the patient being able to stop at any time, if he chose to do so." Even when presented with detailed accounts of cocaine's disastrous effects, he did not waver in his belief that cocaine addiction was no more than the equivalent of the coffee or tea habits. Dr. Hammond's example illustrates that experts can be caught up in uncritical enthusiasm for a drug, especially if they like the effects of the drug on themselves.

But this benign view of cocaine could not last. Within 15 years, the positive image of cocaine evolved into the very opposite image, as threatening as the earlier was hopeful. Here is another parallel with our current cocaine problem that can be seen if you compare cocaine's portrayal in the 1970s as a safe, benign stimulant with its aura of extreme danger in the mid-80s.

There are, however, differences between the first and second stimulant epidemics. First, cocaine entered the marketplace in 1884 with no restrictions on it. It was a fully available substance. The laws and regulations did not come until the public demanded them. Second, in the 19th century the right to control the health professions was reserved to the individual states. Our federal system meant our national government did not have the power common to central governments of other nations to oversee physicians and pharmacists and their use of dangerous drugs. Only as a drug came to be seen as a menace were restrictions enacted, and these restrictions were initially at the state or local level. As a result, we had whatever advantages there are in a free economy in drugs much of the last century. Eventually, the fear of drug use grew so great that the traditional separation of federal from state powers was interpreted to allow, for the first time, federal control of prescribing practices over cocaine and the opiates.

As a first step toward controlling cocaine, its distribution was put in the hands of the health professions. For example, the Atlanta City Council in 1901 made it illegal to provide cocaine in any amount or in any form without a doctor's prescription. In 1906, Al Smith introduced a bill in the New York State Assembly to limit cocaine availability to a doctor's prescription.

When state laws did not prove fully effective, Congress surrounded the health professions with rules and regulations that made the use of an opiate or cocaine a serious matter requiring a tax stamp and careful record

keeping. This federal legislation, known as the Harrison Act, was passed in 1914.

There was a reason behind the laws' increasing restraints. Cocaine, which started out as an all-American drug, useful for everyone who wanted to gain a step in the race of life, from athletes to clergy to orphans, had become the very image of evil and failure by 1900. A chief reason is the appearance and behavior of those who had become hooked on cocaine. In contrast to the opiate user – dulled and nodding – the heavy cocaine user was often paranoid, violent and irresponsible. Fear of cocaine intensified. In 1910, President Taft sent a message to Congress in which cocaine was described as "more appalling in its effects than any other habit-forming drug used in the United States" and as "the most threatening of the drug habits that has ever appeared in this country."

The important difference between addiction to a stimulant and an opiate, say, morphine, can be seen in the heroic life of the "Father of American Surgery," Dr. William Stewart-Halstead. Dr. Halstead was among those unfortunate investigators who began working with the early batches of cocaine in the 1880s. These investigators were unfortunate because they did not know about the mental derangement cocaine could cause. Halstead, who had repeatedly injected himself to learn about cocaine's ability to block pain, became addicted to cocaine. His mind was confused, and he felt a constant craving for more and more cocaine. He was one of the most prominent surgeons in the United States. When he was sought to be the first surgeon-in-chief at the new Johns Hopkins Hospital, his friends helped him get off cocaine through close observation, sea voyages, and even admission to a mental hospital. Finally apparently cured, he did become the head of surgery at Johns Hopkins.

Only after his secret diary was opened in the 1960s did we discover that, after cocaine, Halstead had become addicted to morphine, and remained so for the remainder of his life. Halstead had a difficult time with morphine, but he was able to achieve a great deal. He could never have done so if he had remained on a stimulant. It is important to keep the distinction in mind between stimulants and opioids. I mention this because a couple of years ago I was debating the mayor of Baltimore on this subject, and some people thought Dr. Halstead had been on cocaine all of his life, and there was really no problem. It is very important to keep the distinctions between stimulants and opiates in mind if you are interested in public policy. Maintenance is possible, although difficult, with morphine. But giving more stimulant to a person with a stimulant problem only makes them more anxious and hyperactive. This is a reason why stimulants are more feared than opiates and why stimulant users seek some other substances, like heroin, to take the edge off of their nervousness.

Waves of opioid use tend to be longer and to decline less far compared to stimulant epidemics that tend to be briefer and fall farther.

The mental distortion caused by stimulants probably accounts for another difference from opioids. Waves of opioid use tend to be longer and to decline less far compared to stimulant epidemics that tend to be briefer and fall farther. The last cocaine epidemic almost disappeared while opiate users never declined to such an extent. But when I say "quickly," I am speaking as a historian, for an epidemic can seem to go on for quite a while when you are living through it. The first cocaine epidemic lasted from about 1890 to about 1930, or forty years. Our current epidemic began in the 1970s, so if history is a guide, we still have a way to go as changing attitudes reduce cocaine's use. With regard to public attitudes, there was a broad consensus against drugs in the decline phase of the previous epidemic, broader, I believe, than is evi-

There is an additional complication with cocaine; it is the tendency, at least in America, to enmesh the cocaine problem with other social fears of the time.

dent today. This is important because the rise and fall of a drug epidemic are not independent phenomena like the return of a comet. Citizens' attitudes toward drug use are crucial in determining consumption or rejection. An uninformed public eagerly searching for shortcuts favors a rise in drug use. A public that has seen the unfortunate consequences of drug use is more protected against the extravagant claims for a new drug.

One of the consequences of cocaine and other stimulants is they damage the ability to think rationally. There is an additional complication with cocaine; it is the tendency, at least in America, to enmesh the cocaine problem with other social fears of the time. Around 1900, the fear of cocaine became linked with African-Americans living chiefly in the South. Blacks were accused of heavy cocaine use that led to violence, as in a full page from the New York Times in 1914 in which a drug expert is telling about the great problems among blacks in the South. There is very good evidence that blacks used much less cocaine than whites in the South at this time. The importance of the drug issue often gets mixed up with social issues, and it can be a real disservice to our society. Since this era marked the peak of lynchings and removal of voting rights from blacks, we can see how these accusations could serve other purposes. At one point, even the United States Opium Commissioner was encouraging newspapers in the South to repeat these accusations as a way to obtain Southern support for a national anti-cocaine law.

This Velcro-like attachment of drugs to other social fears arises from the enormous symbolic power drugs come to possess in our society. Too often drugs are given as the entire explanation for social problems, obscuring other and deeper causes. Drugs can be given as a reason for not helping inner cities because so many falsely believe the inner cities are predominately populated by drug users. The history of drugs in America illustrates these repeated misperceptions. Knowing that history may help us curb these flights of fear and accusation.

As cocaine declined in the 1930s, a new stimulant appeared: Amphetamine. This had been synthesized long before but was introduced to the United States only in 1932 as Benzadrine. By the end of the 1930s, Benzadrine was promoted as a treatment for hay fever, melancholy and as a general pepper-upper. Amphetamines got off to a slow start in the 1930s and did not become fairly common until World War II, when they were prescribed for fighter pilots and others who had to stay awake and alert.

Again, you will note the use of stimulants in the role of a technology for the mind. After World War II, investigations of amphetamines implicated them in trucking accidents resulting from their use by long-haul drivers. Amphetamines also played a role in an infamous kidnaping and murder case in the Midwest in 1953. The explosion in use, however, occurred in the 1960s when amphetamine and methamphetamine, or “speed,” became popular among some youth, most notoriously in the Haight-Ashbury District of San Francisco. Methamphetamine has remained popular on the West Coast and recently has spread to the Midwest.

When we look over the history of stimulants in America, we see our past wave of use faded under broad popular condemnation, and we can hope the current one will do so, also. The saddest impact of a stimulant epidemic is the damage done to users who sought some chemical help with life's problems and soon found themselves in a morass of anxiety, hyperstimulation and paranoia. Yet we have to keep in mind there is a substantial learning process that must take place before we reject trying a drug that promises us joy and accomplishment.

By the time drug use had ceased being a major problem, by 1940, the anger and fear had become so overwhelming that the story of past use of drugs was simply repressed in our society. We developed policies that increased punishments rather than treatment, preferred silence to education, and, if descriptions of drugs were necessary, described them in extreme terms that bore little relation to reality. This strategy was not a problem when

drugs were declining in use and their effects were fresh in memory, but the long-term impact was to leave our nation essentially ignorant of drugs. By the time the 1960s arrived, we had re-created conditions of the 19th century, and a more than 50-year struggle with drugs and the practical wisdom painfully gained over those years had been erased from our public memory.

Drugs take their effect when they interact with the brain's physiology, but our response to the problems caused by drugs, the response that may increase or decrease the use of drugs, is a social reaction. When we react, knowledge of the long and dramatic history of drugs in American helps us avoid errors of the past and gives us counsel in making decisions for the future. Thank you very much.

Q One of our churches includes families who work in the meat packing plants. The clergy report many people are using methamphetamine due to the demands of work, a demand to produce more, faster. Do you see historical parallels of drug abuse with today's increase on the demands for workers to produce more and more?

A Physicians and treatment specialists understand people get involved with drugs, not because they are bad or mean people, but due to various pressures. Users think the drug will actually give them something; they will be more with the drug than they could be by themselves. Minors were given cocaine, for example, to work harder, and there is a labor law from the early part of the century about not taking the drugs from the supervisor. It is quite true that, in the late 1930s, there were cases where the management provided drugs to people to work longer and harder because supervisors saw drugs as an instrument to improve work production.

The fact that people are using methamphetamine today for the same reason illustrates one point I always try to make: People do not change over time. Physiology is always the same, and we usually act the same way. If we decide not to take drugs, we have decided from some learning experience not to take them. At the societal level, it is the absence of that learning experience that causes what we call drug epidemics. We must work hard not to forget the past.

Treatment: Effects On the Brain and Body

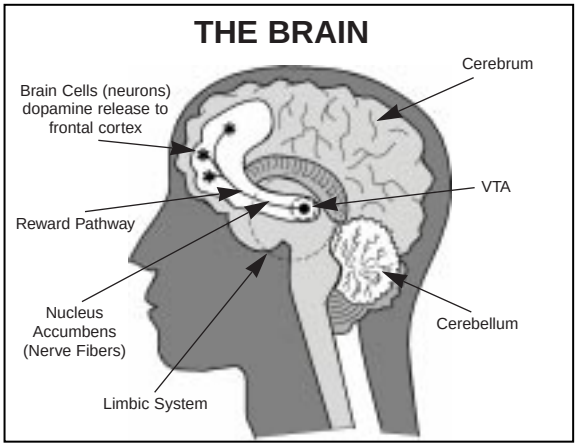
ALAN I. LESHNER, Ph. D., DIRECTOR
NATIONAL INSTITUTE ON DRUG ABUSE

The fundamental problem in dealing with any drug is to understand the target. The advances in science over the last 20 years have revolutionized our basic understanding of the nature of drug abuse and the nature of addiction. Research has taught us a tremendous amount, particularly about methamphetamine as an unusual stimulant with some unique effects. In order to understand what drugs are doing and why a drug is a problem, one must understand why people use drugs.

Most who talk about drug use have a tendency to discuss a wide variety of societal and risk factors for drug abuse and addiction. In fact, there are 72 risk factors for drug abuse and addiction, the same risk factors as for anything else bad that can happen: Poverty, racism, social dysfunction, weak families, poor peer groups. However, those risk factors only influence the possibility an individual might or might not use drugs. When we look at the individual case and ask why someone is using a drug, we need to understand he is using the drug simply because he wants to feel good, and this "feel good" effect has to do with how the drug affects the brain. My presentation outlines this phenomenon.

People take drugs because they like what it does to their brains...

People take drugs because they like what it does to their brains; drugs modify mood, perception, and emotional state. To better understand this effect, we have to understand some basic neuroscience about how the brain works. First, the brain is organized into lobes, which are specific areas responsible for specialized functions like cognitive and sensory processes and motor coordination. The brain is also organized into far more complex units called circuits that involve direct connections among the billions of nerve cells that various drugs of abuse affect. Next, we must focus on the limbic reward system from the VTA (ventral tegmental area) to the nucleus accumbens. This little circuit is probably the essence of addiction. Every abusable substance – alcohol, cocaine, marijuana, nicotine, heroin – all



[1]Dopamine is a chemical neurotransmitter substance. It helps regulate feelings of pleasure (euphoria and satisfaction). Methamphetamine modifies the flow of dopamine in the brain. Too much dopamine may produce nervousness, irritability, aggressiveness and paranoia that approximates schizophrenia. Examples of extreme depletion of dopamine include Parkinson's disease. See *Proceedings of the National Consensus Meeting on the Use, Abuse and Sequelae of Abuse of Methamphetamine*-DHHS Publication No.(SMA 96-8013)

Dr. Alan Leshner, director of the National Institute on Drug Abuse (NIDA), speaks about the dangerous effects of methamphetamine on the brain and body.

have an effect on that system, and substances cause a change in the nucleus accumbens and cause the secretion of a chemical substance named dopamine.[1]

Upon examining the brain, the connection between individual nerve cells and the neurons is important. The action of drugs occurs at a connection between two neurons called the synapse; what happens in this connection is the essence of what drugs do to the brain. An electrical signal comes from the axon to the first neuron and causes the release of a chemical substance called the neurotransmitter into the synapse. The neurotransmitter dopamine then moves to the next neuron where it is taken up by a receptor, or it is brought back by the dopamine reuptake transporter. This is very important because the transporter causes these chemical substances to be brought back into the brain.

Drugs of abuse modify the way in which those chemical substances are released into the space synapse and modify the activity of the receptors on one end or the other. Methamphetamine causes a tremendous release of dopamine into the synapse and causes displacement in little sacs of the dopamine transmitters. For the lay person, *Time Magazine*[2] published an excellent description of what drugs do to the brain, and I commend the article for your reading.

Various drugs of abuse modify dopamine neurotransmission. Methamphetamine produces a "spike" (an increase) in dopamine in the nucleus accumbens. Drug abusers love that spike; the more drug they take, the bigger the spike, and so the purpose of taking methamphetamine is, literally, to produce that spike. Studies at Brookhaven National Laboratories show the duration and intensity of the dopamine spike is directly related to the intensity of the high. This is a very important finding because it shows methamphetamine is different from other stimulants. Though stimulants might all produce a spike, methamphetamine has a gradual falloff in dopamine while cocaine has a more rapid falloff. Drug users binge crack cocaine to keep pushing their dopamine levels up, whereas the methamphetamine addict does not have to binge as much to keep a high.

Use is not just a chemical event. Dopamine is a neurotransmitter substance involving all pleasurable experiences and has a very widespread effect, even though its activity is in a relatively limited circuit in the brain. Some of the effects on the brain and on the behavior produced by acute methamphetamine use include: Increase in tension, decrease in fatigue, decrease in appetite, euphoria and rush, obvious increase in heart rate, and very complicated effects on motor functions. Methamphetamine is one of the most powerful acute stimulants available.

Methamphetamine produces a "spike" (an increase) in dopamine in the nucleus accumbens.

Methamphetamine use can not only modify behavior in an acute state, but, after taking it for a long time, the drug literally changes the brain in fundamental and long-lasting ways. This change in the brain is the problem with

[2] *Time Magazine*, May 5, 1997

methamphetamine addiction -- not physical dependence or the withdrawal symptoms one acquires after one stops taking a drug -- and it is a very dramatic and more long-lasting change. We know a tremendous amount about how chronic methamphetamine use affects the secretion of various neurotransmitter substances, particularly dopamine and serotonin.

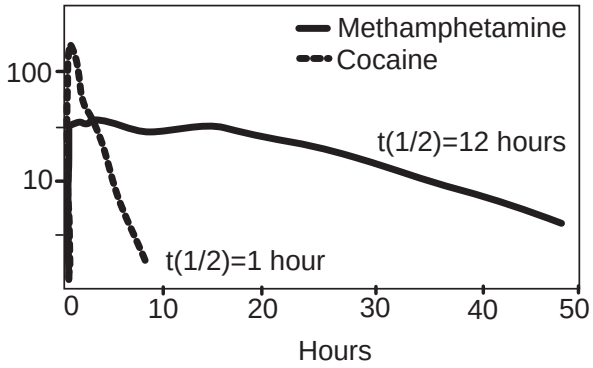
We know brains in addicts are different from brains of nonaddicts, and those differences are an essential element of addiction.

In the March issue of ***Behavioral Brain Research***, William Melega and Mike Phelps from UCLA discuss a study performed on rhesus monkeys about amphetamine effects on the brain. PET (positron emission tomography) scans demonstrate that pre-amphetamine control is a measure of the ability to produce dopamine, and FDOPA dopamine is an indication of the ability to produce the chemical dopamine. Before a monkey was injected with amphetamine, there was an effective ability to produce dopamine in the area of the nucleus accumbens. The monkey then got two shots of amphetamine a day for 10 days. Four weeks after the injections had stopped, there was a tremendous decrease in the ability to produce dopamine. This problem persisted six months later. At one year, the brain was 90% functional, and, by two years later, the brain returned to normal dopamine production.

Fundamentally and at its core, addiction is actually a brain disease that has literally-embedded behavioral and social context aspects.

Prolonged use of amphetamine or heavy use of amphetamines produces a very dramatic change in the brain's ability to manufacture a chemical substance essential for the normal experience of pleasure and for normal psychological functioning. Chronic use has decreased the ability to produce that substance, and this effect may persist for up to a year after the individual has stopped taking the drug. We believe those changes in dopamine and the damage produced to dopamine and serotonin neurons are responsible for the much more dramatic chronic effects of methamphetamine use than the acute effects. Anyone who treats methamphetamine-addicted individuals or heavy users knows there are a wide array of behavior changes that are very dramatic, very persistent and very resistant to any kind of rational discourse. These behaviors are a direct result of what the drug is doing to the brain.

Plasma Levels of Methamphetamine and Cocaine in Man after Smoking



Source: C. Edgar Cook, NIDA Research Monograph 115: 6-23,1991

It is also no surprise that use of the drug produces dependence and addiction. Methamphetamine is among the most addictive substances ever known to humankind. It is also dangerous because it can cause stroke or create methamphetamine psychosis, a mental disorder that may be pure paranoid psychosis or may mimic schizophrenia. It is difficult to define, but it is important for the lay person to understand these people act in a bizarre way, and they act this way because their brains are altered. The truth is that prolonged use of methamphetamine modifies the brain's systematic waves. This is a dangerous consequence, and the public must be educated about it.

What is particularly frightening about methamphetamine, more so than crack

cocaine, is methamphetamine produces neurotoxicity. In animal models, and there is some evidence in humans as well, methamphetamine produces nerve toxicity to dopamine and serotonin neurons. To understand this fact is important, because antipsychotic medications work by changing the activities of the dopamine and serotonin neurons. We treat schizophrenics and psychotic individuals with drugs to reverse or return their brain function to normal. There have been a few studies investigating antipsychotic medications in the treatment of methamphetamine.

So we do understand there are very dramatic brain changes, and the changes persist long after a user stops taking the drug. We know brains in addicts are different from brains of nonaddicts, and those differences are an essential element of addiction. We are beginning to understand there are common brain changes characteristic to every addicting substance. Some of these changes are at a molecular level. After prolonged drug use, the individual moves from a state of drug use into a qualitatively different state of addiction because of what has happened in the brain. Drug use is voluntary behavior; addiction is not.

Addiction is a state of compulsive, uncontrollable drug use – the person is literally in a different brain state. Fundamentally and at its core, addiction is actually a brain disease. It is not a brain disease in which one develops a magic bullet to solve the problem; addiction is much more complex. The final common path to the brain that is influenced by the individual's physiological state, his or her genetics, environmental and societal situation, and how he or she is embedded into society comes together in the end. Addiction is a brain disease that has literally-embedded behavioral and social context aspects.

Perhaps the most important message I could leave is this: We need to face the fact that, when we are dealing with methamphetamine addicts, we are dealing with people whose brains have been changed by drugs and who are literally in a different brain state. Law enforcement officers on the street understand this problem from experience, but we all must understand this fact at a core level if we are to solve the problem. This educational shortfall can be overcome; we learned from Alzheimer's disease and schizophrenia. When I was a graduate student, schizophrenia was believed to be caused by "refrigerator" parents. In 1988, we decided to educate the public that schizophrenia was a brain disease, and we succeeded. We need to do the same with methamphetamine. We need to understand these brains are different, and we need to fix them. That is what treatment is for, and that is what treatment is about -- either to change the brain back or to somehow compensate for that brain change.

CHRONIC CENTRAL NERVOUS SYSTEM (CNS EFFECT OF METHAMPHETAMINE IN MAN

- *Dependence & addiction (sensitization occurs to this effect)*
- *Psychosis (sensitization occurs to this effect)*

  Paranoia
  Hallucinations
  Mood disturbances
  Stereotypic motor activity (e.g. compulsive cleaning & grooming, sorting, & disassembling objects)
- Neurotoxicity?
- Stroke*
- Weight loss (tolerance occurs to this effect)

**Can also be produced by high acute doses*

We need to face the fact that when we are dealing with methamphetamine addicts, we are dealing with people whose brains have been changed by drugs and who are literally in a different brain state.

Addiction is a psychobiological phenomenon of brain disease with behavioral and social context aspects. That tells us the most effective treatments will deal with all of those aspects: Biological, behavioral, environmental

and social. Combined treatments that bring all of those together do well. The problem is that we have virtually no biological treatments for methamphetamine addiction. This is a terrible problem. The absence of medications for stimulant addiction is probably at the core of our inability to get a handle on this issue in this country, and I have declared the development of anti-stimulant addiction medications in my institution as a top priority.

On the other hand, we have tremendously effective behavioral techniques, and I hope at the workshops you will have the opportunity to talk about them. We have in our toolbox more clinical trial case treatments for drug addiction than we do for virtually any other mental or addictive state. We have some effective treatments, if used and applied in a systematic way. The Center for Substance Abuse Treatment (CSAT) recently published a very important study about the efficacy of treatment. Science is providing molecular targets at which to direct our efforts. These advances are helping us in our goal of developing medications.

We at NIDA are making progress. We have declared a methamphetamine research initiative to try to answer questions about this drug and its effects. We are committed to doing our part in the scientific community to increase our understanding of the phenomenon. Let me close with this core message: To a very large degree, the use of this drug is about its effect on the brain. To fix the problem, we will have to address those brain changes, and we will have to do so in systematic and fundamental ways. Thank you very much.

Q You mentioned research on an anti-serum and anti-addiction-type serum. Where are we on this research, and what timeline do you see for research development?

A This is what I call a multiple-strategy approach to an anti-addiction medication. We actually have 26 compounds in various stages of clinical trials at the moment. We are making progress; we certainly have more and more compounds that are candidates. Some of these clinical trials are giving us positive results, but the typical time it takes the pharmaceutical industry to develop a medication is 5 to 10 years. I cannot give an exact date of completion, but I certainly hope to move faster.

Q What about ultra-rapid opioid detoxification (UROD)?

A Literal detoxification is not drug treatment. Literal detoxification addresses the minimal physical dependence aspects of only those substances that cause physical dependence accompanied by dramatic withdrawal symptoms. It is necessary to detoxify people. But after they are detoxified, they must complete drug treatment, or they will not return to functional status in society, which is the goal.

Q How many months or years must a person be in treatment to guarantee some success in the drug court system?

A Addiction is a chronic, relapsing disorder. It is not like breaking a bone. It is more like diabetes and chronic hypertension where there will be or is a high risk of occasional relapse. Addicts must be followed for a very long period and must have access to needed resources if they are to recover. They can become productive members of the community, but that does not negate a booster session some time later. Most people need help managing this disorder for a long time.

Research: Arrestee Drug Abuse Monitoring System

JEREMY TRAVIS, J.D., DIRECTOR
NATIONAL INSTITUTE OF JUSTICE

I am very pleased to be here to present some contributions the National Institute of Justice (NIJ) is making to our understanding of the methamphetamine problem. The data I will present come from a profile of methamphetamine users who have contact with the criminal justice system. Our measurement tool is called the Drug Use Forecasting System (DUF), which we are transforming into the ADAM system, or Arrestee Drug Abuse Monitoring System.

The National Institute of Justice proposal for the ADAM system creates a research infrastructure throughout the nation so each of 75 major cities with more than 200,000 in population will, by the year 2000, have the capability to conduct quarterly interviews with everyone arrested in their jurisdiction, to randomly select for scientific validity, and to take urine samples and other bioassays to quantify the level of drug use. Most importantly, we will also conduct annual surveys in rural and suburban jurisdictions, Indian country and in the Federal District Courts. We must contextualize this drug problem at its local level and develop some understanding of trends and patterns of use across this nation. The ADAM system is our contribution to that effort.

Let me emphasize the uniqueness of the population to be discussed. These people are arrested, brought into the criminal justice system and charged with criminal offenses. This is not a survey of all Americans or only of drug-using Americans. To the extent methamphetamine users are not in contact with the

Jeremy Travis, director of the National Institute of Justice, presents findings from surveys of the Arrestee Drug Abuse Monitoring (ADAM) system.

WHAT IS THE ADAM SYSTEM? AN ARRESTEE SURVEY SYSTEM COMPRISING:

- A national and local Information system on drug abuse, crime, and other social issues
- A scientific, flexible research tool
- Interviews and bioassays at the front end of the CJ system (arrestees)
- Samples from urban, suburban, and rural arrestee populations

NIJ- ADAM SYSTEM 1996
METHAMPHETAMINE RESULTS:

	1995 (%)	*1996 (%)*
San Diego, CA	37.1	29.9
Phoenix, AZ	21.9	12.2
Portland, OR	18.7	12.4
San Jose, CA	18.5	14.8
Omaha, NE	8.1	4.3
Los Angeles, CA	7.5	7.0
Denver, CO	3.8	2.2
Dallas, TX	2.7	1.3
San Antonio, TX	1.5	2.1

criminal justice system, we do not measure them. And to the extent they are not in contact with the urban criminal justice system represented by our 23 cities, we do not measure them.

Our measurements do not reflect reality broader than the adult arrestee population within a limited number of cities where we test and conduct our surveys. The key features of the Drug Use Forecasting System are to take urine samples and interview arrestees in 23 cities across the country. We then present findings on adult male and female arrestees. Let me provide a preview of our latest findings.

These new data are contained in the *1996 Drug Use Forecasting Annual Report*. There are significant differences in the regions between positive tests for methamphetamine within the arrestee population. Only nine of the sites reported substantial levels of meth positives among adult arrestees. Sites where the methamphetamine use is highest include San Diego, San Jose, Portland, Phoenix, Los Angeles, Omaha, Denver, Dallas and San Antonio.

There is a reported decline in tracking in each of these sites with a minor exception in San Antonio, where there is a small increase of 1.5 to 2.1 percent. We see a decline from 1995 to 1996, very significant in some cases. San Diego dropped from 37 to 30 percent. Last year, San Diego reported a higher methamphetamine positive rate than that of cocaine among its arrestee population. The methamphetamine rates have come down significantly in eight of the nine cities we are reporting.

Methamphetamine use profiles among arrestees are different from other drug use

In a drug profile of those arrested, tested and interviewed within the ADAM survey, we see differences by gender, race and age. Methamphetamine use profiles among arrestees are different from other drug use. Female arrestees were slightly more likely to test positive in all categories, and white arrestees were significantly more likely than other arrestees to test positive. Elderly arrestees were also testing positive for methamphetamine use.

The question important to law enforcement and the criminal justice system is this: What are the charges methamphetamine arrestees are facing as they are brought into the criminal justice system? Not surprisingly, many are facing drug charges associated with their methamphetamine use. There is a very high correlation with prostitution in the female population that poses public health problems and enforcement problems for the public health agencies and the criminal justice system at the local level. We also notice a high correlation of violence in criminal behavior.

Another question that poses itself is: In a population known for poly-drug use, what is the correlation between methamphetamine and other drug use? It is particularly interesting that we have very distinct methamphetamine and cocaine population arrestee groups. There are very slight overlaps between the two. Of all the arrestees in the sample cities, only 2 percent tested positive for both drugs. So methamphetamine users are a distinct population in terms of drug use, ethnicity and gender. This finding has implications for criminal justice processing as well as for treatment programs.

There is clear evidence of a geographic spread of methamphetamine use in people in the criminal justice system. The regional patterns are quite significant; for example, there is more use in the west and less in the east. One of the advantages of the ADAM system, particularly in the rural outreach components, is that we will be able to track these geographic changes better.

Overwhelmingly, the transactions were reported to be indoor-business transactions. Most users reported they never bought from someone they did not know.

NIJ also conducted another survey to better understand the market dynamics of methamphetamine abuse. What is the nature of methamphetamine use within this population? What is the frequency and duration of methamphetamine use? What do we know about the market dynamics? What is the frequency with which these users have sought treatment and been sustained in treatment, and what are ultimately the best points and methods for intervention? With these questions in mind, we commissioned a special survey of five western cities, using the San Diego Association of Governments (SANDAG) and research and law enforcement partners in Portland, San Jose, Los Angeles and Phoenix.

The purpose of the study was to examine methamphetamine use patterns and issues in these five cities, to explore the intensity in the drug markets and to ultimately try to tie some of these findings into policy recommendations. For sample sizes, there were 232 people spread over five cities, but we are collecting two more quarters of data and will ultimately publish the findings. Please consider data interpretations preliminary.

The first question we asked is: How do you take your meth? We see informative variations within these five cities. We have a high injection rate in Portland and Phoenix while Los Angeles is higher still, with snorting as the preferred method of ingestion. It is important for us to recognize that, even within what we consider to be a homogeneous population, even within these five cities, we have a very different pattern of use that may have implications for treatment and other purposes. We also wanted to gain a sense of the dictionary of methamphetamine, and we compiled a list of different terms important for law enforcement. We asked questions about preferences: Why do you choose one drug over another? Quite simply, we found users strongly preferred methamphetamine to cocaine.

While we know that methamphetamine gives a stronger high and a longer-lasting effect, the fact that methamphetamine was inexpensive was one reason selected by many people. When asked about any side effects and consequences of methamphetamine use, the study revealed significant physiological and social consequences: Sleeplessness, weight loss, family problems, financial problems, paranoia, problems at work. Regarding the duration of the use, we asked how often people use methamphetamine on more than a single day. The majority of respondents reported they use methamphetamine four or more days in a row on at least one occasion. These are not casual, one-time users; these are people who reported long periods of use on more than one occasion.

We also asked: Where did you get your drugs? The answers are important for the development of law enforcement tactics that respond to the different distribution and purchasing patterns of different drugs. Overwhelmingly, the transactions were reported to be indoor-business transactions. Most users

CONSEQUENCES OF METH USE REPORTED BY USERS

• Sleeplessness	85%
• Weight loss	71%
• Family Problems	62%
• Financial Problems	48%
• Paranoia	45%
• Problems at Work	44%

National Institute of Justice 1996 DUF/ADAM Methamphetamine Data

reported they never bought from someone they did not know. Consequently, policing methamphetamine use is more difficult than the outdoor transaction frequently conducted from stranger to stranger.

Another question was: How difficult is it for you to get your drug of choice and what tends to interfere with your ability to get your drugs? Three-quarters of the interviewees in the five cities said, "I can't remember a time when I couldn't find some methamphetamine." We will use this measure as an indicator of the effectiveness of disrupting the distribution system.

ADAM: PART OF NIJ'S MISSION OF "RESEARCH TO ACTION"

- ADAM links research to action through data and information dissemination
  - *-to the law enforcement community*
  - *-to the drug treatment community*
  - *-to prevention and drug education practitioners*
- At local and national levels
- Informs the evaluation of specific policy programs: drug courts, weed & seed, break the cycle, HIDTA, local initiatives

We asked for a quality assessment compared to a year ago: What is the quality of methamphetamine you are able to purchase today? In San Diego, two-thirds of those we interviewed said quality was worse; few said it was better. In San Jose, roughly a third said it was better while a quarter said it was the same.

We also wanted to look at treatment, particularly in the hard-core drug-user population, the area of concern principally of public safety and health. Many in Portland said they sought treatment, but not so many in Los Angeles and Phoenix. We will look at this question and report on it nationally more frequently as we develop the ADAM system.

Yet there is still more to understand. For example, consider this important question: Are you also engaged in selling? We asked those who were users for a point of comparison; we found significant dual involvement, both in use and in sale. We will soon also analyze data of interest to the law enforcement community about the type of involvement in these selling activities. Is it occasional? Is it the main source of income? What is the intensity of involvement?

In conclusion, these research surveys are a sampling of our work at the National Institute of Justice. We hope our research creates a linkage between the local practitioners, policy makers and researchers. With regard to understanding the methamphetamine problem, the guiding principles are: To look at the methamphetamine problem in a larger context, to think about long-term solutions, to strike a balance between prevention, enforcement and treatment, and to develop timely data and community support.

Many believe there is one national drug problem; my strong views are that there are many national drug problems, and these are best seen from a local perspective. Look at the drug problem facing San Diego; it is a methamphetamine problem. Talk to the police commissioner of Baltimore; there is a large heroin problem. We must understand the local context. The ADAM program will help us develop this local understanding and research so we can track drug trends on a quarterly basis and over a long period of time. The ADAM program will also help us to understand rural drug use. We tend to focus on cities, and methamphetamine is a perfect example of why we need to change that focus to include rural and suburban jurisdictions.

I encourage you at the local level to get involved in the establishment of the ADAM site councils. We ask for enforcement, treatment, criminal justice, public health and education professionals to be at the same table at the local level so that the ADAM capabilities can be yours, not just ours. You can ask the questions important to you. This is not a federal program; it is a local/federal partnership, and I encourage you to get involved so this

can be a tremendous success. Thank you for your time and attention.

Q We have been participating in the DUF program for several years. Ninety percent of misdemeanor criminal violations are handled by a criminal citation rather than physical arrest and booking. Only 10 percent of all misdemeanor violations result in a physical arrest. What role are drugs playing in misdemeanor populations that, in every city, make up a large number of criminal activity situations?

A I have two conclusions: One research conclusion and one policy conclusion. The research conclusion is that we are not accurately reflecting the arrestee population to the extent we miss those who are not in extended police lockup. We must talk about ways to overcome this shortcoming because we are missing an accurate measurement of police and criminal activity.

The policy conclusion is that the criminal justice system must become better in its carrot-and-stick approach to reduce drug use through treatment. The drug court movement is a creative recognition of this need. Substance abuse treatment in prisons, supported on a national level by the President, and the Breaking the Cycle initiative, which NIJ and ONDCP are starting in Birmingham, are approaches to more fully integrate treatment in the criminal justice system.

These actions adopt the "broken window theory," which links criminal behavior and community policing. The theory suggests that it is important to police less serious offenses because failing to do so leads to some of the larger issues of community decay and criminal behavior. We need to apply the same theory to drug policy and treat the low-level drug offender before he or she moves to more serious offenses. At the present, we are missing this point of intervention, and it would be wise to pay attention to it.

Q I am surprised at the data showing reduced use of methamphetamine by an arrestee. Our methamphetamine lab seizures are up 300 percent in two years. California drug teams show methamphetamine is now a plague; teams uncover a methamphetamine lab every 15 minutes. This is not reflected by the data in those cities. What is the cause for this disparity?

A Remember my qualifier? We survey people arrested and charged with crimes. The question to be posed at the local level is: Who is using and who is buying? What are the points of intervention for those not in contact with the criminal justice system? I am open to theories as to why the positive test levels for those arrested in these cities are going down. It may be a different story for each of these five cities. The data presented here suggests production – and therefore use – is increasing somewhere, yet it appears to be declining within the arrestee population.

Intelligence: Trafficking Organizations

RANDY WEAVER, SENIOR RESEARCH SPECIALIST
NATIONAL DRUG INTELLIGENCE CENTER

I will present an overview of the trends and patterns we have associated with Mexican methamphetamine organizations. This information was developed from a comprehensive review of almost 1,500 criminal investigations provided by the Drug Enforcement Administration, the California Department of Justice, Bureau of Narcotics Enforcement, and the Federal Bureau of Investigation as well as information provided by the Western States Information Network.

Copies of our three baseline assessments, *Hazards of D-methamphetamine Production, Effects of D-methamphetamine,* and *Ephedra, Potential Precursor for D- methamphetamine Production,* are provided in your information packets. Thousands of these products have already been distributed to law enforcement, education and health care professionals nationwide, and we are engaging more distribution right now.

The Mexico/Methamphetamine Unit is also working toward the completion of 15 detailed organizational profiles of Mexican methamphetamine organizations. NDIC is producing a CD-ROM format nationwide directory of clandestine laboratory operations, and we are exploring methods to make that information available to law enforcement agencies at all levels nationwide. We have also produced a study for law enforcement entitled *Mexican Methamphetamine: Organizational Trends and Patterns.*

Randy Weaver, senior analyst of the National Drug Intelligence Center, discusses production and trafficking patterns of drug organizations.

This presentation is extracted from that trends and patterns document and will discuss specific domestic and international methods of operation of these Mexican methamphetamine organizations in five different functional areas. These are: Precursor chemicals, lab operations, transportation, drug distribution and money laundering. I will con-

PRODUCTION METHOD

- Many are poly-drug organizations
- Use the ephedrine reduction method
  1. Ephedrine or pseudoephedrine
  2. Hydriodic acid
  3. Red phosphorous

clude with some key observations concerning Mexican methamphetamine organizations.

Many of the larger Mexican methamphetamine organizations are, in reality, poly-drug organizations, and may traffic in cocaine, marijuana and heroin in addition to their methamphetamine activities. Mexican organizations produce methamphetamine using the ephedrine-reduction method, the best-known way to clandestinely manufacture bulk quantities of methamphetamine. There are three essential chemicals required for this method of methamphetamine production: Ephedrine or pseudoephedrine, hydriodic acid and red phosphorous.

Mexican organizations have managed to remain steps ahead of law enforcement in developing and maintaining sources of supply for both ephedrine and pseudoephedrine. They have answered every attempt at regulation with an almost immediate shift to an alternate source. While regulatory efforts have clearly reduced the domestic availability of ephedrine and have had some success in reducing overseas availability, the largest Mexican organizations have little difficulty obtaining bulk quantities of ephedrine.

The primary source countries for ephedrine and pseudoephedrine have fully cooperated with U.S. international control efforts. Mexican methamphetamine organizations have maintained access to bulk supplies of ephedrine and, most recently, phenylpropanolamine, by resorting to smuggling via mislabeled shipments. Despite attempts to control the commerce in pseudoephedrine and ephedrine, China and India have increased production in recent years, increasing the likelihood of illegal precursor shipments. During 1995 and 1996, smuggled shipments from Taiwan and the United States provided phenylpropanolamine to some of these drug traffickers, which they used to replace reduced supplies of ephedrine.

Many Mexican organizations operating laboratories in the United States have turned to pseudoephedrine as a substitute for bulk ephedrine. These labs are supplied with tens of millions of pseudoephedrine tablets per month by rogue chemical companies, many of which do little-to-no business with the retail drug business or the health care industries. These individuals operating networks of liquor stores and convenience stores are the primary conduit through which pseudoephedrine reaches many domestic methamphetamine laboratories. The illicit trade in pseudoephedrine is, in itself, a multimillion dollar annual industry.

Some Mexican organizations establish front businesses to provide large-scale procurement of precursor chemicals.

The historical trends identified for ephedrine and pseudoephedrine also applied to hydriodic acid, but, more recently, trends indicate hydriodic acid is no longer the critical commodity it has been in the past. Because of the difficulty of obtaining and transporting large quantities of hydriodic acid and its increased price, many organizations now add the necessary ingredients to the reaction process, allowing hydriodic acid to be produced as methamphetamine is synthesized.

Some Mexican organizations establish front businesses to provide large-scale procurement of precursor chemicals. Others establish networks of individuals to accomplish that function. These networks use numerous automo-

LAB OPERATIONS TRENDS AND PATTERNS

• Mexico	• United States
- larger	- smaller
- more secure	- less secure
- 150-200lbs	- 10-50lbs
- family owned	- numerous sites
- property	- rented or brokered

• Approximately 5-6lbs of toxic waste per lb of meth produced

biles and disposable individuals know as runners. Runners will purchase chemicals from any company that will sell to them, including some on the East Coast and in Midwestern states. These networks are usually established by larger organizations that specialize in bulk methamphetamine production.

The largest Mexican organizations have production operations in both the United States and in Mexico, but domestic labs differ greatly from labs in Mexico that are usually larger and more secure facilities than those in the United States. Labs in Mexico generally produce far more methamphetamine than labs in the United States, sometimes as much as 150 to 200 pounds per cook performed every other day. By contrast, Mexican organizations in the United States typically maintain three to seven locations that can be used as clandestine lab sites when necessary. Since chemicals and equipment are frequently removed from U.S. lab sites after a cook, U.S.-based cooks usually average only 10 to 15 pounds of methamphetamine per cook, significantly less than the operations in Mexico. Lab operations in the United States for non-Mexican organizations are significantly lower in terms of production capabilities.

Although that trend seems to be continuing, larger lab sites capable of producing more than 200 pounds of methamphetamine have been located in the United States. Labs in Mexico are often located on a family-owned ranch, farm, residence, or in a business. In the United States, labs may be located in an auto body shop, an abandoned mine, a deserted trailer or outbuilding, an apartment, a hotel room or in an orchard. The location of a lab site frequently depends upon the preference of the cooker, but, wherever the lab may be located, one fact remains absolutely constant: Five to six pounds of toxic waste are generated for every pound of methamphetamine produced at a clandestine lab site.

Once a lab site is located and established, organization leaders select personnel who will participate in the manufacturing operation. Methamphetamine manufacturing depends upon persons performing four specific roles. The manager of the entire manufacturing operation is the lab foreman, who is usually a cook himself and a highly-trusted member or leader of the organization. The cooker is also a trusted and usually experienced individual who oversees the actual manufacturing process. The cooker instructs and supervises the lab workers but personally performs the more sensitive tasks of mixing and heating the chemicals.

The least trusted individuals involved in the manufacturing process are the lab workers. They perform the physical labor and hazardous tasks associated with manufacturing methamphetamine. Security personnel are usually trusted individuals who safeguard the lab site from the other organizations and law enforcement. Security personnel also maintain watch over the lab workers and prevent them from leaving the lab site until the cooking process is complete.

TRANSPORTATION TRENDS AND PATTERNS

- Couriers--family or friends
- Transport methamphetamine, ephedrine, and money
- Traditional transportation routes, methods
- Supported by larger organizations
- Automobiles
- Tractor trailers and aircraft
- Mail services

Ideally, these four roles are filled by individuals from the same organization; this affords the greatest measure of security and cooperation but also results in a greater profit margin for the organization. This self-sufficient style of manufacturing methamphetamine is the goal of emerging methamphetamine organizations. While there are many cookers producing methamphetamine, only a few cookers actually possess the skill to supervise a large cook of more than 50

pounds, ensure a high-purity product and train other cookers.

These highly-skilled cookers are frequently associated with more than one production and distribution organization and often work in labs in both the United States and Mexico. Mid- to low-level Mexican methamphetamine organizations frequently exchange cookers, lab sites, precursor chemicals, and at times, even methamphetamine, but they are still very dependent upon a continuous supply of precursor chemicals.

Mexican organizations use couriers who are trusted individuals, family members, or close family friends to move methamphetamine. Couriers associated with lab facilities in Mexico frequently smuggle both methamphetamine and ephedrine into the United States and often carry cash back into Mexico. The transportation of precursor chemicals and methamphetamine into Mexico is dependent upon the same methods, routes, individuals and organizations that have historically moved other contraband through Mexico.

The preferred method of transporting precursor chemicals and methamphetamine is the automobile. These automobiles are frequently equipped with electronically-activated compartments to conceal drugs or chemicals. When transporting contraband in this manner, couriers attempt to avoid any identifiable patterns of behavior. To transport especially large loads of methamphetamine, Mexican organizations have used both tractor-trailer rigs and even private aircraft. To transport smaller amounts of methamphetamine, Mexican organizations will use mail services. The U.S. Postal Service, United Parcel Service and Federal Express have all been used to transport both methamphetamine and cash. The use of mail services allows for easier expansion of distribution to developing market areas outside the Southwestern United States, which remains the core area of operations.

Methamphetamine abuse has become a rapidly-expanding phenomenon of national proportions that poses a major threat to our economy, our society, and the environment.

Finished methamphetamine is frequently uncut until it reaches street-level distributors. Our analysis revealed an average purity level of 80 to 90 percent for even small amounts of methamphetamine, indicating that the responsibility or necessity of cutting methamphetamine rests with street-level distributors. The Mexican Mafia prison gang plays an important role in methamphetamine distribution, especially in Southern California and Arizona. The Mexican Mafia provides a connection to street gangs that methamphetamine production organizations can exploit. With established distribution throughout their ranks, outlaw motorcycle gangs are another important distribution connection for Mexican organization.

Historically, demand at the wholesale level drove the production of methamphetamine, with demand known and quantities and pricing negotiated before methamphetamine was manufactured. Recent methamphetamine seizures indicate the trend may be changing. Seizures of multi-hundred-pound quantities of methamphetamine and reports of methamphetamine warehouses suggest the larger Mexican organizations may be surpassing traditional demand-driven production requirements.

Unlike their Columbian counterparts, mid- to upper-level leaders of Mexican methamphetamine organizations may be personally

DISTRIBUTION
TRENDS AND PATTERNS

- Normally uncut
- Purity 80-90%
- "Mexican Mafia"
- Outlaw motorcycle gangs
- Demand drove production
- Warehousing of methamphetamine
- Leaders personally involved

MONEY-LAUNDERING TRENDS AND PATTERNS

- Unconventional methods
- Desire to hold cash
- Distrust of banks
- Bulk cash transactions
- Smuggling money to Mexico: a major logistical challenge
- Dependent upon the movement of cash

involved in both production and distribution. Leaders of Mexican organizations seem to prefer a more direct measure of control over every aspect of their operations. Many leaders have worked their way up the scale from street-level distribution to leadership within the organization.

Sophisticated, structured laundering of drug proceeds, as practiced by many drug trafficking organizations, is quite rare in Mexican methamphetamine organizations. Mexican methamphetamine organizations do not typically attempt to make drug proceeds appear legitimate through structured deposits and wire transfers. The leaders of Mexican methamphetamine organizations prefer instead to hold their money in cash form or invest in real property. Mexico-based organizations continually transport large sums of cash from the United States to Mexico. Because of their distinct distrust of banks and other financial institutions, leaders of methamphetamine organizations in the United States and Mexico may hide large sums of cash in secure locations, often going as far as burying containers full of millions of dollars in cash.

Directly corresponding to their preference to possess cash, leaders of Mexican organizations also prefer to conduct business transactions in cash, even very large transactions. This method of cash exchange affords them a greater degree of security and simplicity and eliminates any potentially exploitable record of criminal activity.

While their preference to possess cash and conduct business in cash terms is simple and difficult to track, it presents Mexican organizations with a significant logistical challenge, the movement of the cash itself. Larger Mexico-based organizations may move hundreds, even thousands of pounds of cash per year. And since most large cash transactions are still performed in Mexico, continuous operations depend heavily upon the physical movement of tens and, at times, hundreds of thousands of dollars in cash per trip.

Although our initial analysis focused almost entirely on the Southwestern United States, some recent trends in methamphetamine manufacturing and distribution have become apparent. Methamphetamine abuse has become a rapidly-expanding phenomenon of national proportions that poses a major threat to our economy, our society and to the environment.

The number of labs seized in the United States has risen dramatically in the past four to five years. Though smaller labs not directly associated with the Mexican organizations may outnumber Mexican labs numerically, they cannot compare with the volume of methamphetamine and, correspondingly, the volume of toxins produced by Mexican organizations.

Mexican organizations have generally supplanted outlaw motorcycle gangs in methamphetamine production and now use outlaw motorcycle gangs to facilitate their distribution activities. Couriers for Mexican organizations now routinely use domestic commercial airlines to expand distribution to new market areas. There are strong indications that the larger Mexican methamphetamine organizations are supported by even larger organizations like those led by the Arellano-Felix brothers and Amado Carrillo-Fuentes. Our analysis and recent discussions with law enforcement personnel at federal, state and local levels indicate the preeminent Mexican methamphetamine organizations are undergoing a systematic

expansion to areas well beyond their core area.

In summation, the incursion of Mexican methamphetamine organizations into the illicit methamphetamine market has added a level of organization, sophistication and scope that were not the case before their ascension. Mexican organizations now comprise a major portion of the methamphetamine threat to the United States. Again, we appreciate the opportunity to participate and address this conference and, pending your questions, this concludes my presentation.

Q What is the extent of cooperation or conflict between U.S. organizations like the biker gangs and the Mexican gangs or organizations?

A From the information we have seen thus far, it very much appears the biker gangs, in most cases, have accepted the fact that Mexican organizations can produce methamphetamine at a cheaper rate than they can themselves. In the United States, we have seen information that the Mexican organizations are actually selling to or fronting for methamphetamine biker gangs. Meth is then being distributed to other biker gangs or among these organizations in the areas of influence in the United States. NDIC has another study upcoming, another product that is going to detail some of the relationships between Mexican methamphetamine organizations and the outlaw motorcycle gangs.

Q Is there any evidence that restrictions on ephedrine, such as making it a prescription drug or a controlled substance or restricting the number of units for sale at any given time, have any effect on the methamphetamine production?

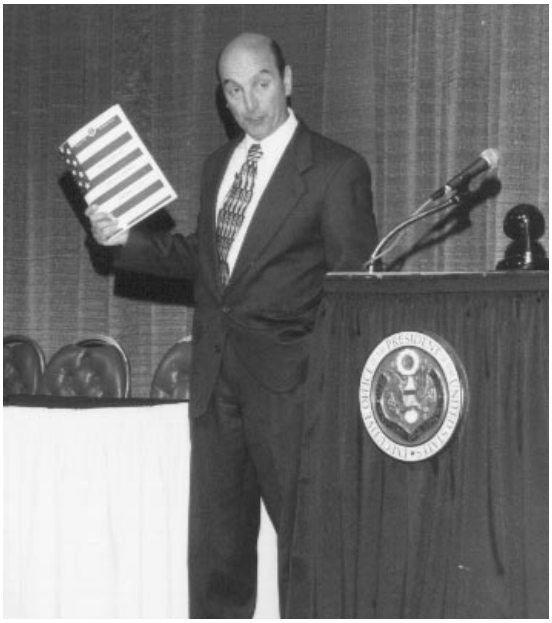
A Absolutely. While it is difficult to comment on the level of methamphetamine production, we do know that lab seizures are increasing. From these seizures, we have seen a very distinct impact as a result of government efforts to restrict the availability of bulk quantities of ephedrine, then ephedrine tablets, and pseudoephedrine tablets: In every single instance, restriction forced these organizations to react and adapt to a different supplier of precursors. Restrictions do create complications for methamphetamine producers.

Strategy: *The 1997 National Drug Control Strategy*

JAMES R. McDONOUGH,
SENIOR STRATEGIST, OFFICE OF NATIONAL CONTROL DRUG POLICY

If I have learned anything in life, it is that there is always hope, and there are always people with goodwill and faith and desire to solve problems. We need ideas from you, and we need execution of those ideas. Our hope is for an America with a will to solve the drug problem we have, not only with methamphetamine, but with the entire drug plight that faces this nation. We have a clear opportunity to proceed against this problem, and the *Strategy* is the roadmap to take us there.

We plan to incorporate your ideas into the collective national strategy, which is a comprehensive approach to drug abuse in America. We have captured the essence of the *1997 National Drug Control Strategy* on pages 30 and 31 of the document. Any strategy must have goals; we have selected a short list of goals that encompass the entire spectrum of what we must do.



James McDonough, senior strategist at ONDCP, presents an overview of the 1997 National Drug Control Strategy.

We put these goals in no particular rank order except the very first goal: Educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco. In other goals, we visit crime, social consequences, health concerns, and what we can do about these problems. Finally, we discuss border control and the organizations that supply drugs to our children and our people. Simply put, five goals are supported by 32 objectives. Let me tell you how these goals play a role in our *National Strategy*.

FIVE GOALS OF THE *NATIONAL DRUG CONTROL STATEGY*

- Educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco.
- Increase the safety of America's citizens by reducing drug-related crime and violence.
- Reduce health and social costs to the public of illegal drug use.
- Shield America's land, air, and sea frontiers from the drug threat.
- Break foreign and domestic drug sources of supply.

First of all, any strategy must exist over time. We must have a long-term view of what we are able to do. Over the next ten years, our ideas will change as we learn, as we succeed in some areas and have a difficult time in others, but the strategy will adapt. As with strategy, we must have resources. We will face tremendous resource limitations, and we must adapt our strategy to fit our assets. Resources have to be planned over time. We will have a 5-year outlook at the resources we need to support this 10-year approach to our nation's drug problem.

Having done that, keep in mind that no strategy survives its moment of issue; it changes immediately upon its impact with the forum in play. Strategy has ideas that sometimes work, but sometimes do not. We plan to look at how the *National Strategy* works. To do this effectively, we place measures against that strategy. Where is success? Where should we reinforce? Where should we try something new? We are now devising a balanced approach to look at each one of the objectives to give us an indication where our strategy needs to change and which new ideas should be tried. What opportunities need to be exploited?

Let us look at the various components of the strategy. When we look at the massive problem of drugs in America, at first glance it seems overwhelming. We then do what we have done here: Break it down into component parts. As we do this, we begin to realize what we can accomplish with each of those parts. Experts across the country have told us the main effort has to be demand reduction, and this is where we plan to focus. It is, after all, this craving for drugs that drives the problem. If people did not want drugs, we would not have a drug problem.

We will focus on demand reduction, but we must ask: Where is the critical focus? Where can we have the greatest effect? Our answer is to look at America's youth. We have 68 million Americans under the age of 17. If we can grow them to adulthood free of substance abuse, we are successful. If we raise them to age 20, and they are not binging on alcohol, smoking, or taking drugs, they are probably not going to start later in life. So our idea is to focus on youth – educate them, protect them, and keep them free of drugs.

The average American youth watches about 18,000 hours of television before he or she graduates from high school; that is more hours than the child spends in school. Did you ever watch teenagers drive? They are listening to music. When they are walking down the street, they are listening to music. When they are walking, they are listening; they are hearing. Media impacts them. We have noted the ads that are intended to warn them about the dangers of drugs have decreased in recent years; we need to increase them.

The average American youth watches about 18,000 hours of television before he or she graduates from high school; that is more hours than the child spends in school.

If we take our target group, our youth, and if we expose 90% of them to the right messages four times a week – positive messages, educational messages that allow them to judge for themselves – we change attitudes. If we change attitudes, we change action. We change practice. We are looking at a $175 million a year ad campaign matched pro bono through the media. Over five years, we will spend about $1.75 billion. Is it worth it if 68 million American youth can grow up to be drug-free adults? Yes, it is worth a generation free of drugs.

We also need to remember that 71 percent of our drug users in America are working. We need to keep them free of drugs, keep them working, and keep them out of prison. We need to help these people into treatment before they progress to more serious drug abuse problems.

We cannot forget about the 3.6 million chronic users who are citizens, too. We heard

the eloquent, compassionate views of the terrible effects of methamphetamine and other drugs that are hurting our people. We have to bring them back; we have to try. We believe we can bring the numbers of chronic users down by helping them into treatment programs.

Our operations should be intelligence-driven and research-based.

If we keep children from using drugs, watch them develop their entire lives drug-free, and we reduce the chronic population of users, we will make tremendous inroads in decreasing drug abuse in this country. These are your ideas, and they are great ideas.

We are a nation of law, and we enforce it. We also have a prison population of 1.6 million, with about 100,000 of those in federal prisons. Sixty percent are there because of drugs. They committed a crime because they had drugs or were distributing drugs or were under the influence of drugs. We have a quarter of a million Americans in the state prison systems because of drugs; most will not spend their entire lives in prison. If they leave prison with a drug addiction, they will have to subsidize it. The addiction they sustained in prison leads to further prison time. We need to stop the vicious cycle; you are telling us to stop it through the drug court system with incentives, disincentives, and abstinence for the nonviolent offender.

Incarceration is necessary as a deterrent, and law enforcement knows how to do that. The deterrent must make sense; it must be rational. The question is: How much deterrence do we need? What is the most cost-effective? Many want to throw away the key. The *National Strategy* lays out markers for what must be done. Above all, the laws must be seen as legitimate and equitable. We cannot allow unreasonable sentencing disparities.

Ours is a team effort.

We also need to remember that 71 percent of our drug users in America are working. We need to keep them free of drugs, keep them working, and keep them out of prison. We need to help these people into treatment before they progress to more serious drug abuse problems. Treatment is a highly cost-effective alternative; it is about one-tenth of the cost to treat a person rather than putting him or her in jail. We will bring the population of adult drug users down while we stop our children from becoming drug users.

If demand reduction is our main effort, we must go to the other side of the street and reduce the supply of drugs. There is a direct cause and effect; if there are more drugs available, more people use them. It is critical to cut the supply of drugs. At the source country, we find methods to displace the production of drug-producing crops and create incentives so that other legitimate enterprises are pursued. We use our intelligence systems and share our information to cut traffickers off at the source, in the transit zone, and at the borders before they arrive into the United States.

At the border, law enforcement moves in a timely manner, organized and sharing information, and stops the supply of drugs. We integrate these enforcement actions with an aggressive search to catch the laundered money. Drugs are sold because they produce money, and we will pursue the money. This need for money is a major vulnerability of the drug traffickers, and we will follow the money trail and stop their organizations.

We focus our efforts in the most consequential and cost-effective manner. Are the most drugs coming across the Southwest border? This is a tough, tough border 2,000 miles long. Some of it is urban, and some of it is wide-open desert. Sixty percent of the drugs enter America across that border through 38 ports of entry. Two hundred thirty-two million people crossed the Southwest border last year, along with 84 million cars and 2.8 million trucks, and drugs are coming over the border with them.

If we make entry more difficult at the Southwest border, what does a trafficker do? He looks for an easier route. About 30 percent of drugs come in from Puerto Rico and the

Virgin Islands, and we need to interdict drugs there. We want to close the back door and close all ports of entry to drugs. Only 2 percent of the world's production of heroin comes into the United States. It comes in small packages, and sometimes it is ingested by the human carrier. We need to develop a good system to break the supply of drugs and ensure we achieve integrated efforts driven by intelligence, then executed by professionals who are committed to the effort.

We cannot do it alone. We are a democracy that exists in a world of nations bound by international law. Because drugs affect other nations and come from other nations, we need to work together to stop drugs. We are working with Mexico; we plan to work in Southeast Asia to create incentives to build multilateral and bilateral protocols. We will develop a joint effort, a combined effort, to halt the flow of drugs. We will go to where the coca leaf is grown and work with those countries to create incentives to displace those crops, to create a better livelihood for those people, and to decrease the supply of drugs entering this country.

We are a great country. When our organizational ability, our leadership, and our people's wills are activated, nothing will stop us. We can put people on the moon and fight great wars, and we can fight drugs and win. We must be smart and use our resources. Our operations should be intelligence-driven and research-based. We are rational people who believe in science; we need to look at the facts, and we need to analyze the facts. We need to organize, and we need to share our capabilities. We need more research, more applications of technology and refined information sharing.

We want to streamline coordination, and we do not want turf battles in the fight to stop the supply of drugs. The objective is to decrease drug use by taking advantage of all ideas, develop new strategies, and incorporate those strategies so each one reinforces the other. What we learned here about solving the methamphetamine problem will work its way into the Strategy.

Ours is a team effort. The federal government cannot attain these goals without state cooperation. We need to turn to concerned communities, listen to them, ask them to help us reach our population and turn off the supply of drugs. We share efforts, as with the High-Intensity Drug Trafficking Areas (HIDTA) program, which brings state and local police forces together with federal agencies. We need to enlist associations such as the National Association of State Alcohol and Drug Abuse Directors (NASADAD), the Boy Scouts of America, Boy's Clubs, the Elks, and all groups concerned about this problem. The *Strategy* details this effort over a 10-year period.

What are the essential elements of the *National Strategy* summed up? We are a nation of principles; the rights of individuals are highly important, as is the social good. We also recognize we are a democratic nation in an international system that abides by the rules of law and sovereignty. We are outcome-oriented; we know no silver bullet will solve this problem. We must weigh everything and take advantage of every long- term opportunity. The *National Strategy* is wide-ranging; it is concerned about what is happening in Omaha as it is looking at what is coming out of Burma. It is a comprehensive program with international and domestic approaches, intelligence assistance, integration of air, land, sea efforts, reinforcement of the borders, support for law enforcement, and whatever else we can add to break the supply of drugs.

It is a comprehensive program with international and domestic approaches...

The *Strategy* is realistic. Do not think we can leave this conference and have methamphetamine vanquished, once and for all. The *National Strategy* takes into account that we can make more and more progress without introspection. The Strategy has no arrogance to it. It does not say, "This is it; we have the answer." We turn to you to draw up a strategy, and we turn to you to improve it. We take a hard look at what we are doing to make it work and make it better. That, ladies and gentlemen, is the *National Drug Control Strategy*.

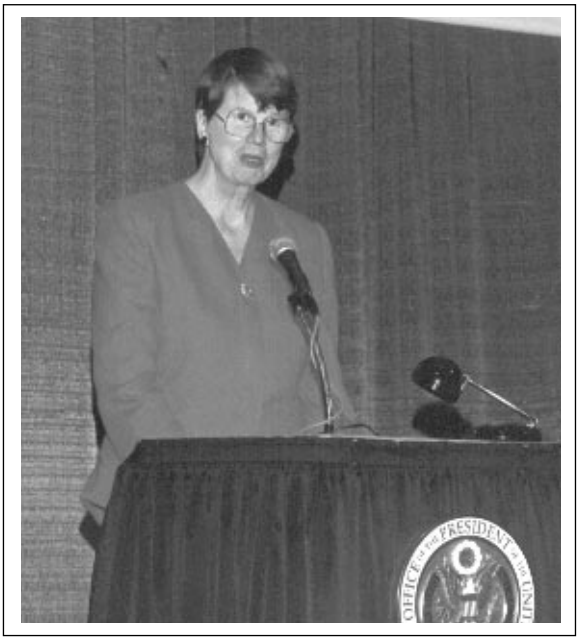
Keynote Dinner Address

JANET RENO
UNITED STATES ATTORNEY GENERAL

Since I came to Washington, one of the finest events that happened is General McCaffrey becoming the drug czar. He has real energy, common sense, and an ability to bring people together to address the challenge of drug abuse. It is a great pleasure to work with him. Senator Kerrey and Governor Nelson, it is wonderful to return to Nebraska. This is my third trip to a state with leaders dedicated to do something to address drug problems before they become too complicated and cost much money and tragedy. Tom Monaghan is the United States Attorney for Nebraska, and it is a great privilege and pleasure to serve with you. I appreciate your outstanding work for the Department of Justice.

Tonight, I want to explain what we have done and what we should do to further address the methamphetamine problem. Let us first reflect upon the past. In 1985, we noticed a significant increase in cases coming into the criminal justice system in Dade County. We saw an increase in violence, and we did not know what was happening. We began to hear about crack, but we still did not know what was happening. We slowly began to recognize the connection between the two, but it was too late. I watched crack tear up neighborhoods. I watched violence destroy lives. I watched both cause terrible misery and tragedy in families. I watched the court systems become overwhelmed with crack cases. So when I first heard about methamphetamine, I directed the Department of Justice to work with state and local law enforcement to create a straightforward plan that would keep us ahead of the problem.

Key to this strategy is starting with a prevention plan that forms a partnership among law enforcement, treatment, and prevention specialists.



Attorney General Janet Reno speaks about the importance of partnership among federal, state and local officials.

Tom Constantine, the outstanding administrator of DEA, suggested we bring state and local law enforcement into the decision-making process because they are on the front line. We put together a strategy based on a partnership in law enforcement with the federal, state and local officers across the country, working together with two-way communica-

tion that permits the full exchange of information. The law enforcement strategy permits us to determine who can best handle the case to rid drugs in that community and not worry about turf or who takes credit. Resolving drug problems like crack or methamphetamine, however, cannot be done just community by community. We must approach the problem from a regional and national perspective as well. Key to this strategy is starting with a prevention plan that forms a partnership among law enforcement, treatment and prevention specialists.

But what does prevention mean? I am a child advocate because I read too many presentence evaluations of young people I had convicted for drug abuse. I saw points in their lives where someone could have intervened and made a difference. Whether it is crack, methamphetamine, or alcohol, we must make an investment in the lives of our children if we are going to be serious about prevention. This requires more than telling our young people not to use drugs. We must present our young people with facts and a better understanding of the issue because they are very intelligent. It has been revealing and gratifying to me to meet those people who know how to communicate with young people and who are developing the best prevention strategies and program content. They can truly educate our youth about what drugs can do and why they should not use them.

For a long time, it has bothered me that there is a waiting list for treatment in this country. People are seeking treatment, whether it is for methamphetamine or any other substance of abuse. They want to be treated but are wasting away on a waiting list, in danger of using the drug again. We must develop the capacity to treat addicts in this county as we treat for other illnesses, and this will require treatment specialists to work with other providers to develop the most cost-effective means for doing so. Treatment could include long hospitalizations, or it may mean less expensive drop-in centers. We must find the best, most cost-effective way of treatment rehabilitation.

We must educate this nation that, if someone fails treatment once, it does not mean we necessarily give up. If somebody has cancer and has a recurrence, we do not give up. We must adopt the same philosophy with respect to treatment because we can ultimately prevail if we keep trying in a large number of cases. There are still going to be people who break the law, get caught with drugs, and get arrested. But it is that arrest that can be so important in their rehabilitation. The shock of hearing a police officer advising of their rights or of hearing the jail door lock behind them often precipitates these people into treatment. I went to see some of my clients who were graduates from addiction treatment programs. Many of them got there because of an arrest and because of the fear of what would happen next. That is how we came to design the drug court. It takes many different forms across this country, and it has to be tailored for different substances – methamphetamine in one instance, crack in another – but drug court is an effective carrot-and-stick approach to reducing drug abuse.

We must find the best, most cost-effective way of treatment rehabilitation.

We need to expand the concept of drug court, not only to the first offenders charged with possession of a small amount, but to those who are in prison -- and who should be in prison -- but who are coming out. We must develop a philosophy that says, "If you get yourself cleaned up, and work with us in job training and placement, then we will get you out in an orderly, graduated way. But you are going to be supervised and, if you mess up, you are going to back to prison." We can reform many lives, but we need everyone in this room working to help think through this idea.

We have people who deal in methamphetamine and who kill. These people – traffickers, major dealers, large-scale distributors – should be put in jail for a long, long time, and that is what my business is about: To enforce and tar-

get the major distributors and the people who deal in this misery.

Yet, what else needs to be done? We need to develop and execute a national, comprehensive plan for targeting, prosecuting, convicting, and sentencing rogue chemical companies that supply the precursor drugs in every state across this country. Judging by comments I have heard here tonight, this entire conference has been a wonderful opportunity for people to learn about aspects of the problem. This type of conference can make such a difference in the long-range solution.

There are a number of initiatives underway, but we must do more. What can we do to provide better support, training, and assistance for state and local law enforcement, for laboratory assistants and experts?

Training is essential in every aspect surrounding methamphetamine. We must train federal prosecutors who may not know the distribution issues. We must train DEA and FBI agents, and we have to do more for the state and local law enforcement. These are real heroes, quite frankly. They are on the front lines on so many different issues. They may catch a robber one night, and the next night stumble upon a lab. They are protecting us, and we must provide them with training they need to protect themselves and to do the job properly.

There are a number of initiatives under way, but we must do more. What can we do to provide better support, training and assistance for state and local law enforcement, for laboratory assistants and experts? What can we do to provide the technical expertise necessary to ensure safe laboratory takedowns? How can we better train state chemists and forensic scientists on the issues they face under cross-examination? I really appreciate the opportunity to hear from you what we can do to improve training.

One of the characteristics General McCaffrey and I share in common is a desire for information – to know who is doing what. It gratifies me to see representatives of NDIC here, to see the attention paid to the necessity for developing a good, solid intelligence base of history and of current information. On a nationwide basis, we can then focus on the priorities, agree on the priorities and work together across the country with federal, state and local prosecutors and successfully take down trafficking organizations.

I have told DEA Administrator Tom Constantine that I will try to find more resources for his agency. When state and local law enforcement does not have the capacity to take down a lab or is unfamiliar with the problem, or if it is a small jurisdiction that has never had the problem before, we must ensure the DEA will have the necessary resources to respond. That is a big order, but it is something we must be able to provide, and we are going to do everything we can. If we are having problems along those lines, I want to hear about it.

We still need to decide what is necessary in legislation. Prosecutors across the country came back to us with recommendations as to what was necessary and urged increased sentences of methamphetamine and some chemical traffickers. They urged large fines for those who knowingly sell chemicals to traffickers, and they asked to further heighten regulatory controls. Last August, Congress passed the Comprehensive Methamphetamine Control Act of 1996. It directs the U.S. Sentencing Commission to increase the penalties for trafficking methamphetamine and precursor chemicals and to consider higher penalties for clandestine lab operators who mishandle ignitable, corrosive and toxic chemicals that pose a risk to public safety and to the environment.

The sentencing guidelines actually issued do not go quite as far as we would like, but they will result in higher penalties, and I think they will make a difference. Again, I think it is important we work together to develop any additional legislation necessary. For the agents who have been on the front lines and the prosecutors who handle these cases, if there is corrective action that needs to be taken, let us work together to come up

with legislation that can make a difference.

The regulatory aspects of our strategy seem arcane some of the time, but they are among the most important and effective tools we have because methamphetamine must be synthesized from precursor chemicals. Regulatory control of a select group of chemicals poses great promise in curbing clandestine manufacturing. A law passed last October will tighten controls by limiting the resale of drug products containing precursors or chemicals such as ephedrine and pseudoephedrine. The regulatory aspects of the law do not become effective until this October. Proposed DEA regulations will soon be ready for publication.

We will need to examine the impact of the new law, and, in particular, whether the law's regulatory exemptions for pseudoephedrine and ephedrine sold in blister packs is effective or is being exploited by the traffickers. We need to make sure we hear from everyone across this country as to how we develop the most effective regulations possible.

We have many problems that affect Mexico as well. The General and I worked together and had an excellent visit to Mexico. I had one of the best meetings to date with the Attorney General of Mexico, who is very sensitive to these issues, is very forthright and is trying hard. We are making progress. We have a long way to go together, but I think we are on the way.

What have the successes been? Jeremy Travis's latest figures from the Drug Use Forecasting System indicate methamphetamine use dropped in the arrestee population, so we may be having some success and deserve a pat on the back. Then someone says, "Maybe it's ephedrine that is being used now." Let us find out and understand what is happening. Whether it is fewer arrests or hospital emergency room admissions, we need to know why the data are changing. The problem may have become more rural in nature, and we are not seeing it because we do not measure outside the cities. Therefore, let us approach this inquiry from a scientific point of view and develop the information we need to make the best judgment.

I do know, if we take the knowledge in this room from treatment professionals, prevention specialists, and law enforcement officials and use that knowledge, we can make a difference.

It is wonderful to listen to you, and I will go back with lists that are good bases for action. Tom Monaghan, what you and the other United States Attorneys have done to develop regional strategies against methamphetamine is truly commendable. The more we can help local law enforcement, the better. We want to be your partners. We do not want the credit; we just want to do everything we can to support you and get the job done.

I do not know the answers, but I do know, if we take the knowledge in this room from treatment professionals, prevention specialists and law enforcement officials and use that knowledge, we can make a difference. If we work together as partners and do the job, based not on the credit, but what is in the best interest of this nation, we can prevent a tragic situation such as with crack. I saw neighborhood after neighborhood and community after community brought to its knees by a terrible substance. If we work together, we will be able to look back with pride about how law enforcement, prevention, and treatment came together to defeat this terrible drug problem.

To everyone in this room, all I can say is thank you for your dedication to this issue and for all that you do for your communities. All of you are little lower than angels. Thank you for your attention.

Keynote Luncheon Address

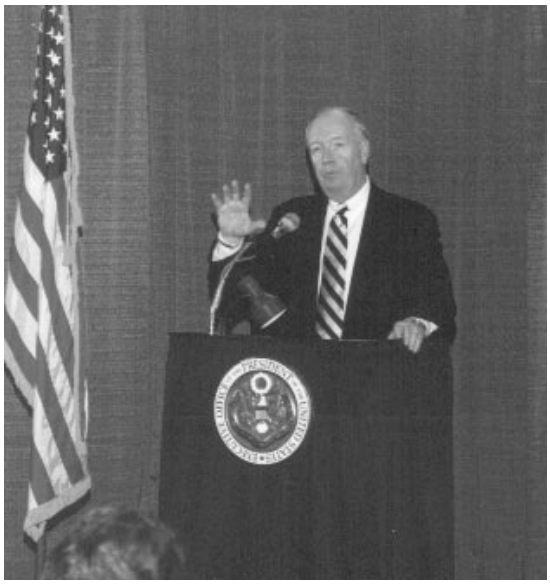
THOMAS A. CONSTANTINE, ADMINISTRATOR
DRUG ENFORCEMENT ADMINISTRATION

Often a drug or crime problem does not seize the attention of people in Washington until it has affected a city, town, village or state. This is the issue with methamphetamine. I will discuss how the DEA learned about this problem and what we are doing to address it. I will also show the value of this conference and the impact you can make on this drug problem.

A small group of chiefs of police met in San Diego in May, 1995, to discuss the drug problem, drug leadership and organizations from Colombia. At the end of the meeting, representatives from the California Narcotics Officers Association and the California Bureau of Narcotics Enforcement asked if they could spend extra time with us. They brought a series of reports about and indicators of the methamphetamine problem in California. They asked if we would examine the data to determine if their situation were unique, and if it were not, to develop programs at the national level.

An astonishing statistic emerged from Iowa: law enforcement made more methamphetamine arrests than drunken driving arrests.

We found the situation was not limited to California. The methamphetamine problem had moved to the Southwest and to the Midwest, where there had been a tripling of hospital room admissions for the use of methamphetamine. We looked further, and in Oklahoma City, there were 12 deaths related to methamphetamine in an 18-month period. In the next 12-month period, there were 36 deaths, a major increase for that community. I immediately recognized that the Iowa situation was as good an empirical study as one could possibly get about an emerging drug problem.



DEA Administrator Tom Constantine describes enforcement efforts against drug trafficking organizations.

I tasked two DEA staff, Catherine Shaw and Dave Luitweiler, to organize a conference to learn about the issue. We decided this would not be a conference where the feds would dictate what the problem was and what the solution would be. Having been on the other side of a number of those events over the years, I knew such an event was an inadequate way to address the problem. I wanted input

from the people who know the problem best: Law enforcement on the front line. We invited state and local law enforcement to give us their knowledge of the problem and make recommendations to address it. We were able to issue a report. We got tremendous support from Attorney General Reno and General McCaffrey, and the follow-up actions of these two conferences, here and in San Francisco, are extremely valuable.

Methamphetamine is a very dangerous and violent form of drug trafficking. Drug trafficking, in general, began with crack cocaine in 1985 and changed from a nonviolent criminal enterprise to an extremely violent one. It is no coincidence that trafficking of methamphetamine and other synthetic drugs carries the same amount of violence. Compared to crack, methamphetamine may have more potential impact on violent crime and may create more danger for law enforcement officials.

Methamphetamine trafficking and production are different from other drugs because they are dangerous from beginning to end. It is a very dangerous action when untrained people decide to manufacture a fairly sophisticated synthesis of chemicals and precursors to make a drug. These unsafe practices result in a continual series of explosions and fires that injure or kill not only the people and families involved but also law enforcement officials or firemen who respond to clandestine laboratory sites. Environmental damage is another consequence of these improper actions, and violence is a part of the process.

If you are a uniformed law enforcement officer, you are probably exposed to potentially violent situations. These can include a domestic complaint or a barroom fight, a boundary dispute or a traffic stop, but such encounters all have the potential for violence. Usually a well trained and well-equipped officer can control a tense situation before it becomes dangerously violent. However, when confronting a paranoid and delusional person, the usual tactics are often worthless. These times are, perhaps, the most frightening part of an officer's career.

In the DEA, where our focus is on trafficking of drugs and criminal activity, we have two very distinct problems with trafficking in methamphetamine in the country. The first, and by far the largest, is an organized crime problem. In a fight for organized crime control of the methamphetamine and ephedrine market in San Diego in 1993, there were 26 homicides involving a major international organized crime group out of Mexico and local street gangs in San Diego. The second are the small laboratories for individual usage. Drug trafficking has now created a tremendous organized crime system throughout the world that visits us with a vengeance. The individuals who control a great deal of this methamphetamine trafficking are much more powerful than Gigante, Gravano or Gotti.

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And what makes them so powerful? These organizations have the ability to obtain wholesale, multi-ton quantities of precursor chemicals. They have access to tremendous smuggling and distribution routes. They traffic many drugs, from marijuana to black tar heroin to cocaine. It is very easy to move methamphetamines using the same people, the same group, and the same strategy.

The Amezcua brothers are the best example. The Amezcuas are the experts on the importation of ephedrine into Mexico, and they control the methamphetamine trafficking. From 1993 to early 1995, the Amezcua brothers took a trip throughout the world and bought 170 tons of ephedrine. This makes 120 tons of methamphetamine. We at DEA are continually tracking these patterns, but the drug trafficking organizations are resilient. They can also be very effective in creating a demand for new drugs where none existed previously.

The other trafficking pattern is small labs known as "mom and pop" labs. Police refer to

them as "Beavis and Butt-head" labs, which gives you a sense of the individuals who are involved. In Missouri, our DEA officers, along with the state and local agencies, are almost beside themselves trying to handle the number of investigations, lab entries, lab seizures and environmental cleanups. There were 12 labs seized in 1994, 236 labs seized in 1996, and we estimate we will take down almost 500 labs in 1997.

Our Mobile Enforcement Teams (MET) are groups of DEA officers who can move anywhere, go into a community where there is a problem with drugs and violence and help local law enforcement resolve the problem.

What is our response to these two problems? First, we are improving our skill at attacking organized crime. For example, we have a joint group with the DEA, the FBI, virtually every other federal agency, and as many as 40 or 50 state or local agencies. This group has evolved into a major organized crime investigation unit we call the Southwest Border Strategy, which involves about a hundred organized crime investigations with more than 1,000 court-ordered wiretaps – 400 this year alone. These wiretaps are important because they are the only way we can get into these groups. Undercover agents cannot penetrate these organizations. Informants are reluctant to cooperate because they are often foreign nationals whose families are under threat of execution if the informant cooperates with law enforcement.

With its price-scanner technology, Wal-Mart is now able to limit sales and control pseudoephedrine purchases.

An emerging problem with wiretaps, however, is with encryption systems. Director Freeh has taken a lead on this issue because this is a major technical problem, a developing modus operandi for communication systems to be encrypted. It is difficult for us to translate a jumble of numbers rather than a conversation. We now find, especially with the groups from Mexico and Colombia, continual encryption of any key conversation, and the level of encryption devices seems to grow continually. We must develop technology to counter this encryption problem.

The second action we took was to increase our investigations from 1,500 to around 2,500 per year. Our Mobile Enforcement Teams (MET) are groups of DEA officers who can move anywhere, go into a community where there is a problem with drugs and violence and help local law enforcement resolve the problem. We help make the arrest, and the police chief or local sheriff or prosecutor takes the credit for it, and we move to another community. We have done this in Nebraska; I met with a sheriff, and he was ecstatic he had received that kind of assistance.

Third, we are training state and local officials to conduct clandestine lab seizures. Unlike executing a search warrant, seizures require a very elaborate protocol that most law enforcement people do not know. DEA has trained 540 state and local officers this year, and we will train an additional 800 next year. We have tripled the numbers of trainers, and we have regionalized the training with a site in Kansas City, Missouri, and another one in San Diego. We are developing a database with the California Bureau of Narcotics Enforcement at the El Paso Intelligence Center (EPIC) to track all of the laboratory sites which, heretofore, has not been done.

Fourth is the issue of rogue chemical companies. Pseudoephedrine is becoming the precursor drug of choice for laboratories, large or small. The traffickers have taken advantage of this drug. More importantly, some companies not interested in the legitimate manufacture of the drug are now supplying the traffickers. DEA focused on one, and, in less than one month, that one has already purchased more than 90 million pseudoephedrine tablets, totaling more than 1.8 billion tablets a year. This number presumes all of us have terminal asthma, every man, women and child in the country. This is not true, of course; they use it for other purposes.

Fifth, we are developing law enforcement/business partnerships. We heard this idea from a workgroup at the San Francisco methamphetamine conference. The workgroup suggested DEA develop a program link with the legitimate drug industry that would determine where the diversion of the precursor chemicals was, and what might be done to address it. Our DEA employee in St. Louis, Dave Walkup, worked out an arrangement with Wal-Mart, a major manufacturer with a great deal of technology. With its price-scanner technology, Wal-Mart is now able to limit sales and control pseudoephedrine purchases.

Finally, DEA is making its facilities available to over 90 senior executives from industry associations, major wholesale distributors, manufacturers and retail distributors. It is our hope to form workgroups to help legitimate industry control the problem – not to overregulate them – and to improve our ability to pursue criminal enterprises. This is a classic example of business and law enforcement working together to solve a problem without resorting to regulatory law. We are seeing the same positive experience in California with Price-Cosco and Shucks Market.

These are just a few of the initiatives and problems we face in fighting methamphetamine abuse. Allow me to conclude with this thought, based upon my 34 years of law enforcement experience: We can make this a better world. There was a generation before me in age, fading and dying, that saved America. They went through the Depression, through World War II, and made sacrifice after sacrifice. As a result of their efforts, we now have a generation that lives in a land of opportunity and opulence without threat of world war. We have an economy with low inflation that provides a job for anyone who wants to work. We can take care of our basic needs and still buy the latest products on the market. Behind this success, however, is the ugly drug problem that destroys our children and erodes our greatness.

DEA Administrator Constantine, Senator Kerrey, and Director McCaffrey greet participants at an evening reception.

I think it is our responsibility in this generation, like never before, to save our country from drug abuse. It may not be as dramatic as World War II and the Depression, but we have the responsibility and an opportunity to ensure methamphetamine does not become the crack cocaine of the 1990s. If we miss this opportunity, I believe we will visit upon our children and grandchildren a country unworthy of those sacrifices made by the past generation. This is a great country, and if we work hard, we can defeat this drug menace. Thank you very much.

Prevention: Public Information Initiatives at Home and Work

CO-CHAIRS: LESLIE BLOOM, PARTNERSHIP FOR A DRUG-FREE AMERICA, AND MARTHA GAGNÉ, AMERICAN COUNCIL FOR DRUG EDUCATION

Recommendations:

- Use prevention strategies and regularly quantify their effectiveness.
- Develop a comprehensive prevention program.
- Focus on the context of substance abuse and the nature of addiction in its entirety.

We recognized the power of the media to influence and strengthen anti-drug attitudes. The workgroup agreed that a national public information campaign specific to methamphetamine is needed. The group recommended we use existing strategies and regularly quantify effectiveness using existing methodologies such as Drug Use Forecasting (DUF) or media tracking systems.

The prevention effort should be comprehensive, culturally sensitive, and targeted to proper locations and specific populations, such as youth or parents. Studies show teens are getting less information from their parents about drug abuse. Parents who used drugs in the 1960s do not know how to approach their children without being hypocritical. It is so important to educate those parents because they can make a difference in their children's lives. Teens who hear from their parents are half as likely to use drugs as those whose parents do not speak to them on this topic. More education is also needed in the workplace. We need more businesses to adopt substance abuse policies and challenge workers to talk to youth about drugs.

Working group chairs deliver a summary of recommendations for improving the national response to methamphetamine abuse.

Finally, it is important to focus the prevention effort not only on methamphetamine but also on the substance abuse issue as a whole. All drugs, including gateway drugs like alcohol and tobacco, must be addressed. The prevention campaign should be controlled at the state level with federal leadership and resources in a supporting role.

Education: School and Community Partnerships

CHAIR: KENNETH BIRD, Ph.D., SUPERINTENDENT,
WESTSIDE SCHOOLS

Recommendations:

- Make partnerships based on local needs-based assessment.
- Develop wellness-oriented programs that are outcome-based and cost- effective.
- Make a clearly articulated curriculum with appropriately trained personnel.

Our goal was to explore the need for school-based education initiatives. We are clear that we are not dealing with an exact science in education. One input does not result in a specific output. Our group recognized that drug education is not an event but a journey. It requires systematic, ongoing, research-based programming that starts early and includes all levels of education. It must have a consistency of message and respond to the unique educational and emotional needs of our young people.

Drug education is vitally important, and schools have unique opportunities to start early with this program. Schools provide consistent education and support for young people; they are an excellent location to teach appropriate socialization skills and can play a critical role in helping students combat negative peer pressure. Schools have a responsibility to develop the student fully and can provide family support to those who need it. It is important to remember that some families cannot fulfill their drug-education responsibility alone; they need help from the school and community.

Although schools play a vital role in the education process, it is not an exclusive role, and partnerships are needed. Partnerships – a melding of school, business, church and community – must be tailored to specific school and community needs. We must not forget to include students in the partnership. Any program must be wellness-oriented, holistic in approach, cost-effective, research-based, and reasonable with respect to expectations. We lack research in the drug education arena. We need hard data, and we must develop and articulate an effective curriculum. The program should be sustained with adequate funding and trained staff.

Treatment: Implications for Prevention and Law Enforcement

CHAIR: EVERETT ELLINWOOD, M.D.,
DUKE UNIVERSITY

Recommendations:

- Comprehensive assessment and treatment with effective referral from a wide variety of sources.
- Conduct research to identify and develop effective treatment modalities across the spectrum of methamphetamine abuse.
- Develop empirically-based prevention and education strategies for at-risk populations.

First, we need effective referral with comprehensive assessment and treatment. Effective referrals are needed so clients do not get lost in the system; this includes referrals from family, medical emergency rooms, drug courts, and the workplace. We developed the acronym P.A.T.O.A., which stands for Patient Assessment and Treatment with Outcome Assessment. We must tie outcome assessment to treatment programs. We also recommend long-term financial care because many methamphetamine abusers are depressed and without energy for six months to a year.

Second, our group thought it important to conduct research to identify and develop effective treatment modalities across the spectrum of methamphetamine use. By "across the spectrum" we mean: The youth who is beginning to experiment with methamphetamine or other drugs; the blue-collar worker who is using methamphetamine daily for eight hours but who is not yet into a heavy binge pattern; or the housewife who is trying to reduce her weight.

These types of cases must be distinguished from the more intense, neurotoxic individual who has, as Dr. Leshner pointed out, lost a third of his or her dopamine neurons. Also, clinical research shows that females develop a sensitization to addictive behavior much faster than males. The heavy user is quite different from the casual user who, in turn, is different from the first-time experimenter. We must be able to treat different types of users.

Finally, we thought a prevention and education strategy should be empirically developed and targeted at specific at-risk populations such as youth, housewives or truck drivers. We should learn how to integrate unions and business groups that have drug-free programs into this strategy. Video conferencing to rural areas and mobile medical offices would also help.